MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

16385

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis, Mo (No. City Hosp No 2 ..... St. ..... Ward)

File No. .....

Registered No. 14270

2. FULL NAME Lula Thompson

(a) Residence. No. 1617 1/2 Linden St., 25 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
MUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 3, 1891

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
35	7	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Texas

PARENTS

10. NAME OF FATHER: Square Garrett

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ga

12. MAIDEN NAME OF MOTHER: Nancy Colvin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Texas

14. INFORMANT: Anna F. Woodard
(Address) City Hospital #2

15. FILED MAY -6 1927, 19 ..... Max C. Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 2 1927

17. I HEREBY CERTIFY, That I attended deceased from March 26, 1927 to May 2, 1927 that I last saw her alive on May 2, 1927 and that death occurred, on the date stated above, at 11 10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23 [illegible]

..... (duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) J. W. Gray, M. D.

, 19 (Address) City Hosp. No 2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Washington Park

DATE OF BURIAL: 5-7- 1927

20. UNDERTAKER: Peoples Und Co.

ADDRESS: 3100 Franklin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.