

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

Do not use this space.

16665

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis, Mo.** (No. **City Hosp. 102**)

File No.....

Registered No. **4564**

St. \_\_\_\_\_ Ward)

**2. FULL NAME**

(a) Residence. No. **1611 Wash** 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 **30** 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 **Wgn.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **J. H. Woodward**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb 10, 1887**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than day, hrs. or min.
<b>46</b>	<b>3</b>	<b>3</b>	<b>3</b>	<b>—</b>

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Landress**

(b) General nature of industry, business, or establishment in which employed (or employer) **—**

(c) Name of employer **—**

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) **Miss.**

**10. NAME OF FATHER**

**Nathan Jones**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) **Ala.**

**12. MAIDEN NAME OF MOTHER**

**Emma Parker**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) **Ark.**

**14.**

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

**15.**

FILED **MAY 10 1927** **Wash. Starkeoff**  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 13 1927**

17. I HEREBY CERTIFY, That I attended deceased from **May 13** 19 **27** to **May 13** 19 **27** that I last saw h. u. alive on **May 13** 19 **27** and that death occurred, on the date stated above, at **4:40 a. m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Cardio Renal Disease**

**95 B** Indefinite yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

**90 B** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

20. WAS THERE AN AUTOPSY? **No.**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical & Lab.**

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

, 19 (Address) **City Hosp. 102**

\*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

**Greenwood**

DATE OF BURIAL

**5-16-27**

20. UNDERTAKER

**W. S. Wade & Co.**

ADDRESS

**4202 Finney**

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.

