

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

Do not use this space.

16836

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Petersburg** (No. **1908 R. Wash**)

File No.....

Registered No. **4787**

St. .... Ward)

**2. FULL NAME**

**Opie Brown**  
**1908 R. Wash**

(a) Residence. No. .... St. **21** Ward. ....

(Usual place of abode)

(If nonresident give city or town and State)

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Female** 4. COLOR OR RACE **Colored** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Jal Brown**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 16-1906**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**20** **10** **1**

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

9. BIRTHPLACE (CITY OR TOWN) **Miss**  
(STATE OR COUNTRY)

10. NAME OF FATHER **Alb Right**

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

12. MAIDEN NAME OF MOTHER **Little Creek**

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

14. INFORMANT **Jal Brown**  
(Address) **1908 R Wash.**

15. FILED **MAY 21 1927** **Marie Starceoff**  
19. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **5-17-1927**

17. I HEREBY CERTIFY That I attended deceased from **5-17-1927** to **5-17-1927** that I last saw her alive on **5-17-1927** and that death occurred, on the date stated above, at **6:30 a.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Lobar pneumonia**  
**108**  
**190** **10/10**  
(duration) yrs. mos. **28** da.

CONTRIBUTORY **Exposure to cold**  
(SECONDARY)  
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **Place of Death**  
IF NOT AT PLACE OF DEATH, DATE OF

DID AN OPERATION PRECEDE DEATH? **no** DATE OF  
WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **no**  
(Signed) **Acac William Johnson** M. D.  
**5-17-1927** (Address) **4039a Primmy**

\*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 **West Paris Miss** DATE OF BURIAL **5-21-1927**

20. UNDERTAKER **W S Wade** ADDRESS **4202 Primmy**

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.

WHILE PRINTING WITH OBTAINING INK--THIS IS A PERMANENT RECORD

