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

Do not use this space.

16943

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. 4898

2. FULL NAME Mamie Prince

(a) Residence. No. 1224 No 8th St., 25 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 59 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): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: not known

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 4, 1867

7. AGE: Years 59 | Months 10 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laundress.
(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): Mo

PARENTS

10. NAME OF FATHER: Frank Young

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): not known

12. MAIDEN NAME OF MOTHER: Moore

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): not known

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

15. FILED MAY 25, 1927 Mark Starkcoff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 7 1927

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1927, to May 7, 1927, that I last saw her alive on May 7, 1927, and that death occurred, on the date stated above, at 1 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
131
93 C (duration) yrs. mos. 2/ ds.

CONTRIBUTORY (SECONDARY): Chronic nephritis
Indefinite (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 V. | DATE OF BURIAL: 5/13 1927

20. UNDERTAKER: W. Richter | ADDRESS: 3500 Rutger

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.

[illegible], WITH UNFADING INK—THIS IS A PERMANENT RECORD