

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

Do not use this space.

17174

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis, Mo. (No. City No. Mo.) St. Ward)

File No.
 Registered No. 5207

2. FULL NAME

(a) Residence. No. 2710 Morgan 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 5 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 negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 5, 1883

7. AGE YEARS MONTHS DAYS 43 6 22
 If LESS than 1 day, ... hrs. or ... min.

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

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

10. NAME OF FATHER Mollie Draper

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

12. MAIDEN NAME OF MOTHER Kate Draper

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

14. INFORMANT Annist Woodard
 (Address) City Hospital #2

15. FILED JUN - 1 1927 Moh. Starkoff
 19... REGISTRY

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 27 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1927 to May 27 1927
 that I last saw h. or alive on May 27 1927 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
93c
 (duration) 1 yrs. mos. da.
 CONTRIBUTORY Chronic myocarditis
 (SECONDARY) Indefinite
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 NOT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Chromal & tubercular
 (Signed) J. W. Gray, M. D.
 , 19 (Address) City Hosp. Wm.

*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 6-9-1927

20. UNDERTAKER Peoples Ind. Co. ADDRESS 3100 Franklin

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.

