

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

Do not use this space.

23274

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

File No.....

Registered No.....

7003

City.....

(No. *4422 Maffitt*)

St.....

Ward.....

**2. FULL NAME**

*Mammie Neal*

(a) Residence. No. *4422 Maffitt* St., *11* Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* 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

*Tom Neal*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 20<sup>th</sup> 1875*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*52 1 9*

**8. OCCUPATION OF DECEASED**

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

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

(c) Name of employer

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

10. NAME OF FATHER  
*Jackson Clark*

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

12. MAIDEN NAME OF MOTHER  
*Julia Whaley*

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

14. INFORMANT  
*Tom Neal*  
(Address) *4422 Maffitt Ave*

15. FILED *1927* *Mano Staroboff* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 29 1927*

17. I HEREBY CERTIFY, That I attended deceased from *July 10<sup>th</sup> 1927* to *July 29 1927*, that I last saw her alive on *July 28 1927*, and that death occurred on the date stated above, at *2:30 P.M.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Cerebral Apoplexy*

*90d* (duration) yrs. mos. *13* ds.

CONTRIBUTORY (SECONDARY) *Myocardial Insufficiency*

*Unknown* (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?  
*Autopsy*

(Signed) *S. J. M. D.* (Address) *812 N. Jefferson*

\*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 Center* DATE OF BURIAL *Aug. 3 1927*

20. UNDERTAKER  
*A. L. Beal* ADDRESS *2726 Lucas Ave.*

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.

