

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

Do not use this space.

25722

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township **St. Louis MO**

Primary Registration District No. **1003**

City **St. Louis MO** (No. **2035a**) **Engenia**

File No.

Registered No. **7320**

St. Ward)

2. FULL NAME

Mary Bess

(a) Residence. No. **2035a Engenia** St., **22** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **2** 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

Col

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

Single

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

9/6/1905

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
21	10	4	

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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Ark**

10. NAME OF FATHER

Rance Bess

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **M. C.**

12. MAIDEN NAME OF MOTHER

Laura Hargrave

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Ark**

14.

INFORMANT **Laura Bess**
(Address) **2035a Engenia St**

15.

AUG 13 1927 **Mary Starckoff**
FILED 19 **REGISTERED**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug 10 1927**

17. I HEREBY CERTIFY, That I attended deceased from **July 25 1927**, to **Aug 10 1927**, that I last saw him alive on **Aug 7 1927**, and that death occurred, on the date stated above, at **3 P** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chol. Tuberculosis
2 1/2 yrs (duration) **3** yrs. **3** mos. **3** ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, **at home**

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

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**

(Signed) **Robert M. M. D**

1111 - 1, 1927 (Address) **27357 Franklin**

*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 Cemetery** DATE OF BURIAL **8/14 1927**

20. UNDERTAKER **Dunn Bros** ADDRESS **2158 Jefferson 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.

PERMANENT RECORD

