

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

Do not use this space.

25747

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City **St. Louis** (No. **City Hospital #2**)

File No.....  
Registered No. **7348**  
St. .... Ward

**2. FULL NAME**

**Nannie Hawkins**  
(a) Residence. No. **7614 N. Broadway St.**, Ward. ....  
(Usual place of abode)  
Length of residence in city or town where death occurred **44** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**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) **Jan. 9, 1883**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**44 | 7 | 1**

**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) **Mo.**

PARENTS

10. NAME OF FATHER **Patrick Hyatt**

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

12. MAIDEN NAME OF MOTHER **not known**

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

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

15. FILED **AUG 15 1927** **maile Starkey** REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY That I attended deceased from ..... 1927, to ..... 1927 that I last saw him alive on ..... 1927, and that death occurred, on the date stated above, at ..... m.

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

**General Peritonitis**  
**117A**  
**ruptured Gastric Ulcer** (duration) ..... yrs. .... mos. .... ds.  
**Indigestion** (duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

**NOT AT PLACE OF DEATH**

18.1. WAS THERE AN OPERATION PRECIPITATE DEATH? **Yes** DATE OF **8-9-27**

18.2. WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **clinical**

(signed) **J. Thomas, M.D.**

Address **City Hospital #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 **new Bethel** DATE OF BURIAL **13 1927**

20. UNDERTAKER **E.W. Roberts** ADDRESS **30357**

COPYING INK--THIS IS A PERMANENT RECORD

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.

