

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

Do not use this space.

25842

1. PLACE OF DEATH

County Registration District No. **791**
 Township Primary Registration District No. **1003**
 City *St. Louis* (No. *4308*) *Tray*

File No.
 Registered No. **17452**
 St. Ward)

2. FULL NAME

(a) Residence. No. *4308 Tray* St. *11* Ward.
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Caucasian* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 1 - 1872*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>55</i>	<i>6</i>	<i>15</i>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Nurse*
 (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) *St. Louis*

10. NAME OF FATHER *Case Perkins*

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

12. MAIDEN NAME OF MOTHER *Patricia Perkins*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN); (STATE OR COUNTRY) *St. Louis*

14. INFANT (Address) *Genevieve Taylor 4308 Tray*

15. FILED *JUG 19 1927* *maul Starkeoff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from *Aug 17 1927* to *Aug 17 1927*, and that I last saw her alive on *Aug 15 1927*, and that death occurred, on the date stated above, at *5:30 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronch. Pneumonia
187 A
 (duration) yrs. mos. da. *7*

CONTRIBUTORY (SECONDARY) *100 W*
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: *W*

19. DID AN OPERATION PRECEDE DEATH: *W* DATE OF

20. WAS THERE AN AUTOPSY: *W*

WHAT TEST CONFIRMED DIAGNOSIS: (Signed) *Chas. A. Tubbs*, M. D.
 , 19 (Address) *3711 A So. Blvd*

*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 *8-19-27*

20. UNDERTAKER *W. S. Wade & Sons* ADDRESS *4202 Finney*

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.

