

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

Do not use this space.

25861

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City St. Louis (No. 2644 Seizer)

File No.

Registered No. **7472**

St. Ward)

2. FULL NAME

(a) Residence. No. 2710 Allen St. 23 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 18-27

7. AGE YEARS MONTHS DAYS 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Mo.

10. NAME OF FATHER James B Sparks

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

12. MAIDEN NAME OF MOTHER Hella Lipp

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

14. INFORMANT James B Sparks (Address) 2710 Allen Ave

15. FILED AUG 20 1927 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-20 1927

17. I HEREBY CERTIFY, That I attended deceased from 8/18, 1927, to 8/19, 1927 that I last saw h. a. alive on 8/19, 1927 and that death occurred, on the date stated above, at 2:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth
1.57 7 mo gestation (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONCERNED DIAGNOSIS.....

(Signed) St. J. M. M. D. , 1927 (Address) 6811 Groves

*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 S. S. Peter + Paul DATE OF BURIAL 8-20 1927

20. UNDERTAKER W-C. Moydell ADDRESS 1926 Allen Ave

WRITE PLAINLY, WITH UNFADING 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.

