

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

Do not use this space.

25885

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

St. Louis (No. Peoples Hospital)

File No.....

Registered No.....

7498

St.....

Ward.....

2. FULL NAME

(a) Residence, No.....

(Usual place of abode)

Ward.....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

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

Female Colored Married

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

Cupnes McCarty

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

1-1-1893

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

34 7 18

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

Housewife at home

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Jackson Tenn

10. NAME OF FATHER

William C. Clever

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn

12. MAIDEN NAME OF MOTHER

Jennet Lane

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn

14.

INFORMANT

(Address)

Cupnes McCarty 16527 Calumet Chicago

15.

FILED

19

Mar C Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Aug. 19, 1927

17.

I HEREBY CERTIFY, That I attended deceased from

8/17, 1927, to 8/19, 1927
 that I last saw him alive on *8/19, 1927*, and that death occurred, on the date stated above, at *5:50 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Dilatation of Heart
12 1/2 hrs
9 1/2 hrs (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Appendectomy
Appendicitis (duration) yrs. mos. *1 1/2 ds.*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

11715 DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *8/18/27*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?

Clinical

(Signed)

Geo. R. Commissiong, M. D.

, 19

(Address) *2803 Pine St.*

*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

DATE OF BURIAL

St. Peter's Cem 8-22, 1927

20. UNDERTAKER

ADDRESS

Peoples Undertakers 3100 Franklin

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

OCT 6 1947

JUL 8 1947