

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

Do not use this space.

26140

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis, Mo.* (No. ....)

File No. ....

Registered No. **7771**

**2. FULL NAME**

*Acie Wilson*

(a) Residence. No. *2316 Carr* St., *21* 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. 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* | *col* | *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *sept. 11<sup>th</sup> 1900*

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<i>26</i>		<i>11</i>	<i>7.5</i>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Miss.*  
(STATE OR COUNTRY)

10. NAME OF FATHER *not known*

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

12. MAIDEN NAME OF MOTHER *not known*

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

14. INFORMANT *J.C. Wilson*  
(Address) *2316 Carr St.*

15. FILED *5-1-1927* *Mayb. Starckoff*  
19 *27*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug. 26 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Aug 5* 1927, to *Aug 15* 1927, and that

that I last saw him alive on *Aug 15*, 1927, and that death occurred, on the date stated above, at *6 A.M.* m.

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

*Carcinoma of uterus (cervix)*

*4 1/2* (duration) yrs. *3* mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. *at home*

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

20. WAS THERE AN AUTOPSY *No*

WHAT TEST CONFIRMED DIAGNOSIS. *clinical*

(Signed) *Francis J. Mulla, M.D.*

*111-30, 1927* (Address) *2335 Frank 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

*Greenwood* DATE OF BURIAL *sept. 1st 1927*

20. UNDERTAKER ADDRESS

*Cement and Walton* *2700 Wash*

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.

REGISTER

