

Dr. Keaton

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

Do not use this space.

28331

1. PLACE OF DEATH

County.....

Registration District No. 791

File No.....

Township.....

Primary Registration District No. 1003

Registered No. 7834

City St. Louis (No. 3218)

Lassalle St

St. \_\_\_\_\_ Ward)

2. FULL NAME

Floretta Mines

(a) Residence. No. 3218 Lassalle St., 18 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 Female

4. COLOR OR RACE Colored

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) May 16 - 1967

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 20 3 15

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Richard Munn

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

12. MAIDEN NAME OF MOTHER Emilia Johnson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Georgia

14. INFORMANT (Address) Emilia Munn  
3218 Lassalle

15. FILED SEP - 2 1967 Man & Starceoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 27 1967

17. I HEREBY CERTIFY That I attended patient from July 27, 1967 to Sept 27, 1967 that I saw him alive on 31st Aug 1967 and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Salpingitis  
Non Puerperal Monococcus  
35A (duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY (SECONDARY) 40B (duration) yrs. mos. ds.

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

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical exam

(Signed) W. H. Keaton, M.D.

(Address) 2740A Franklin

\*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 9-5-67

20. UNDERTAKER C. W. Roberts ADDRESS 3085 Lucas

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.

