

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

Do not use this space.

28370

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **City Hospital # 2**)

File No.
 Registered No. **17887** St. Ward)

2. FULL NAME

Gladys Humphrey
 (a) Residence. No. **4338 1/2 Ferdinand St. J. Ford.** (If nonresident give city or town and State)
 (Usual place of abode)

Length of residence in city or town where death occurred **Life** 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 **Negro** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OR (OR) WIFE OF **Percy Humphrey**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec. 25 1900**

7. AGE YEARS MONTHS DAYS IF LESS THAN I day, hrs. or min.
26 | 8 | 8

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) **St. Louis, Mo.**
 (STATE OR COUNTRY)

10. NAME OF FATHER **Overitt Smith**

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

12. MAIDEN NAME OF MOTHER **Georgia Lynn**

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

14. INFORMANT **Anna J. Woodard**
 (Address) **City Hospital # 2**

15. FILED **SEP - 5 1927** **make start of**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept. 3, 1927**

17. I HEREBY CERTIFY That I attended deceased from **6/11/27**, 1927, to **9/3**, 1927, that I last saw him alive on **9/3**, 1927, and that death occurred, on the date stated above, at **10:20 a. m.**

THE CAUSE OF DEATH WAS AS FOLLOWS:
Pulmonary Tuberculosis

About 3 1/2 (duration) yrs. mos. ds. **23 1/2**

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

18. WHERE WAS DISEASE CONTRACTED **not known**
 IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **Clinical xph**
 (Signed) **Dr. Howell**, M. D.
 , 19 (Address) **City Hosp. # 2**

*State the DISEASE CAUSING DEATH, or in deaths from VOLUNT 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 **9/6, 1927**

20. UNDERTAKER **D.S. Williams** ADDRESS **3232 Pine**

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.

