

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

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis mo* (No. *2822 Pine*)

File No. **28431**

Registered No. **7956**

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

**2. FULL NAME**

(a) Residence. No. *2822 Pine* 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. *2* mos. *29* da.

How long in U.S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

*Female*

4. COLOR OR RACE

*negro*

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

*Baby.*

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

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

*Jan 7-27*

7. AGE

YEARS *0*

MONTHS *2*

DAYS *29*

IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. OCCUPATION OF DECEASED

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

*nil*

(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

*Charlie Gaines*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

*New Orleans*

(STATE OR COUNTRY)

*La.*

12. MAIDEN NAME OF MOTHER

*Birdie Diggs*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

*St. Louis*

(STATE OR COUNTRY)

*mo.*

14.

INFORMANT

*Birdie Diggs*

*2822 Pine St*

15.

FILED

*SEP -7 1927*

*May C Staloff*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9-4-27*

17.

I HEREBY CERTIFY, That I attended deceased from *9-3-1927*, to *9-4-1927*, that I last saw him alive on *9-3-1927*, and that death occurred, on the date stated above, at *8:45 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Broncho pneumonia*  
*Primary*  
*1095*  
*158* (duration) yrs. \_\_\_\_\_ mos. *1* da.

CONTRIBUTORY

(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Dr. Edward Beal*, M. D.

*9-7-1927* (Address) *129 South Luning Ave*

\*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

*Greenwood Cemetery*

*Sept. 7th 1927*

20. UNDERTAKER

ADDRESS

*A. L. Beal*

*2726 Lucas Ave*

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.

