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

Do not use this space.

28567

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 28567

Township ..... Primary Registration District No. 1003 Registered No. 8100

City St. Louis (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Cora Rayford

(a) Residence. No. 1721a Wash St., 25 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 6 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 OF~~ (OR) WIFE OF Ernest Rayford

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 28, 1897

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
30	7	11	

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) Miss.

PARENTS

10. NAME OF FATHER Wallace Williams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Miss.
12. MAIDEN NAME OF MOTHER Lula Jordan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Miss.

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

15. FILED SEP 12 1927 19 Max R. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 9, 1927

17. I HEREBY CERTIFY, That I attended deceased from 8/20, 1927, to 9/9, 1927 that I last saw her alive on 9/9, 1927, and that death occurred, on the date stated above, at 4:25 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

23A

Miliary Tuberculosis Lungs

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (SECONDARY) 37A

(duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF 9-9-27

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? X ray

(Signed) T. E. Cunningham, M. D

, 19 (Address) City Hospital #2

*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 9-14-1927

20. UNDERTAKER: [illegible] — ADDRESS 4202

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD