

**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. **1002**
 City..... **St. Louis** (No. **2415 N Newstead**)
 Registered No. **28855**
 St. Ward **8411**

2. FULL NAME

(a) Residence. No. **2415 N Newstead** 11 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

1. SEX Female
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Cooper
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 15 1875
7. AGE YEARS 51 MONTHS 9 DAYS 4
 If LESS than 1 day, hrs. min.
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Landlady**
 (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) Mo
10. NAME OF FATHER **Eliza McFadden**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER **Elizabeth Prince**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT (Address) **John Cooper**
2415 N Newstead

15. FILED **SEP 21 1927**
Wray @ Starkley
 REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **9-19-27**

17. I HEREBY CERTIFY That I attended deceased from **9-17-1927**, to **9-19-1927** that I last saw **her** alive on **9-19-1927**, and that death occurred, on the date stated above, at **7:30 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Double Lobar Pneumonia

108 / 1010
1943 / 010 (duration) yrs. mos. **3** da.

CONTRIBUTORY (SECONDARY) exposure
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? **at place of death**

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

20. WAS THERE AN AUTOPSY? no

21. WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) **Oscar William Johnson**, M. D.
9-20-1927 (Address) **4039 1/2 Perry**

*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 **Fredericktown Mo** **DATE OF BURIAL** **9-22-27**

20. UNDERTAKER **W. S. Wade & Co. Funeral Home** **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.

