

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

Do not use this space.

28981

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis mo.* (No. *4033*) *Papine* St. Ward)

File No.
 Registered No. **8564**
 St. Ward)

2. FULL NAME

Anna Sydney
 (a) Residence. No. *4033 Papine* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Colored* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 16, 1885*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 6 8

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Housework 11 20 921*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Helena Ark.*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Nick Lockett*

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

12. MAIDEN NAME OF MOTHER *Not Known*

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

14. INFORMANT *Harry Ison*
 (Address) *4033 Papine St.*

15. FILED *SEP 26 1927* *Ma C Starkey* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9/24 1927*

17. I HEREBY CERTIFY That I attended deceased from *9/23* to *9/24* 19*27*
 that I had seen him alive on *9/23* and that death occurred, on the date stated above, at *9/24* in

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Indigestion from eating Fresh Ice Cream & Butter pills (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *Mitral Insufficiency* (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? *No* DATE OF WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *E. G. Taylor, M.D.*

9/24, 1927 (Address) *3131 Chestnut*
 *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 27 1927*
 20. UNDERTAKER *A. L. Beal* ADDRESS *2726 Lucas Av.*

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.

