

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

Do not use this space.

29076

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. **791**  
Primary Registration District No. **1003**

File No. ....  
Registered No. **8664**  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **3428 Washington St.** Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred **26** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | Colored | Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **6-12-1880**

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

**47 | 3 | 15**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Housework 117A**  
(b) General nature of industry, business, or establishment in which employed (or employer) **129**  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Franklin**  
(STATE OR COUNTRY) **Ind.**

10. NAME OF FATHER **Not known**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

12. MAIDEN NAME OF MOTHER **Not known**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Not known**

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

15. FILED **SEP 29 1927** **McL. B. Shaw**  
19 **1927**

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from **September 7, 1927** to **September 27, 1927**  
that I last saw him.... alive on **September 27, 1927**, and that death occurred, on the date stated above, at **5:10 P.M.**

THE CAUSE OF DEATH WAS AS FOLLOWS:

**General Peritonitis**  
..... (duration) ..... yrs. mos. ds. **13 ds.**  
CONTRIBUTORY **Ruptured Gastric ulcer**  
(SECONDARY) ..... (duration) **Indefinite** ds.

**18. WHERE WAS DISEASE CONTRACTED**

**11/10/27**  
IF NOT AT PLACE OF BIRTH.....  
DIED IN OPERATION PRECEDE DEATH? **yes** DATE OF **9/19/27**  
WAS THERE AN AUTOPSY? **yes** **9/27/27**

WHAT TEST CONFIRMED DIAGNOSIS? **Autopsy**  
(Signed) **J. J. Thomas**, M. D.

\*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.  
**City Hospital #2**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

**Washington Park** DATE OF BURIAL **Oct-1 1927**  
20. UNDERTAKER **Peoples Burial Co** ADDRESS **3100 Franklin**

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.

