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

Do not use this space.

31803

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 9160

City St. Louis (No. Barnes Hospital St. ..... Ward)

2. FULL NAME Arizona Burton

(a) Residence. No. 2112 Morgan St., 21 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 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: 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) Unknown

7. AGE: abt 35 YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

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) Louisiana

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Arzolia Milan
(Address) 2112 Morgan St

15. FILED OCT 14 1927 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-11-1927

17. I HEREBY CERTIFY, That I attended deceased from 9-24, 1927, to 10-11, 1927 that I last saw her alive on 10-11, 1927, and that death occurred, on the date stated above, at 6:15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Genalized Peritonitis (B. Coli)
Pelvic Abscess
40B
Prob. Gonorrhea (duration) ..... yrs. ..... mos. 18 ds.

CONTRIBUTORY (SECONDARY) Salpingitis bilateral — Ovarian Cyst non malig (duration) 3 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
2. DID AN OPERATION PRECEDE DEATH? Yes { Cul de sac drainage of pelvic abscess DATE OF 10-11-27
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Clinical findings + Autopsy
(Signed) Myron W. Davis, M.D.
10/11, 1927 (Address) Barnes Hospital

*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: Monroe La
DATE OF BURIAL: 10/14 1927

20. UNDERTAKER: C W Roberts
ADDRESS: 3035 Lucas

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