

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

Do not use this space.

32073

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis (No. City Hospital #2)

File No. 9446  
Registered No. 9446  
St. .... Ward)

**2. FULL NAME**

Elliza Wilson  
(a) Residence. No. 2132 Lexington St. 22 Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 1 yrs. 6 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 Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (or) WIFE OF George Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
abt. 40 ? ?

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. Domestic 82<sup>131</sup>  
(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

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 (Address) Myra F. Woodard  
City Hospital #2

15. FILED CCT 23 1927 19. May 6 Starkloff  
REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/19/1927  
17.

I HEREBY CERTIFY, That I attended deceased from 10/18/1927 to 10/19/1927 that I last saw her alive on 10/19/1927, and that death occurred, on the date stated above, at 11:50 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral apoplexy  
1290  
Cholephotic (duration) yrs. mos. ds. 3

CONTRIBUTORY (SECONDARY) red pinta (duration) yrs. mos. ds.

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

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

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical as lab  
(Signed) L.B. Hurrell M. D.  
, 19 (Address) City Hosp. #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 DATE OF BURIAL  
Washington Park Cemetery 10/24 1927

20. UNDERTAKER ADDRESS  
Dunn Bros 215 S. Jefferson

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

