

**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. 1903
 City St. Louis Mo (No. City Hospital) St. 1 Ward 27

File No. 34712
 Registered No. 19830

2. FULL NAME

Laura Key
 (a) Residence. No. 2832 Clark Ave. 22 Ward. (If nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred 5 yrs. 1 mos. 0 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 Laura Key

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 16, 1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
30 4 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) at Home.
 (c) Name of employer

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

10. NAME OF FATHER Green Brooks

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

12. MAIDEN NAME OF MOTHER Lula Folkman

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

14. INFORMANT X Edna Key
 (Address) 2832 Clark Ave.

15. FILED NOV - 3, 1927 May 6 Starkeoff
 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 2 1927

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at 4 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Stab Wound of
Abdomen
By Knife
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) suicide
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 1928
 IF NOT AT PLACE OF BIRTH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) Wm Dewar, M.D.
11/3/27 (Address) Dep Coroner

*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 Brooklawn DATE OF BURIAL Nov 6 1927

20. UNDERTAKER R.M.C. Green ADDRESS 3517 Locust Ave

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.

