

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

Do not use this space.

35119

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **10274**

City **St. Louis** No. **City Hospital #2** St. Ward)

2. FULL NAME

Ernest Raymond

(a) Residence. No. **17211^a W. 25th** St., **25** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. **1** mos. **28** da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept. 4, 1927**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **1 28**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis, Mo.** (STATE OR COUNTRY)

10. NAME OF FATHER **Ernest Raymond**

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

12. MAIDEN NAME OF MOTHER **Cora Williams**

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

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

15. FILED **NOV 17 1927** **Marb Starney** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from **9/4/27**, 19... to **11/2/27**, 19... (that I last saw her alive on **11/2**, 19... and that death occurred, on the date stated above, at **9:10 a.m.**)

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pneumonia
159 16/10 yrs. mos. da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**

(Signed) **Dr. Howell** 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 **POTTERS FIELD** DATE OF BURIAL **11-18-1927**

20. UNDERTAKER **R. Weston** ADDRESS **2945 Lawton**

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.

