

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis* (No. *City Hospital #2*)

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

File No. *35345*
Registered No. *10530*
St. Ward)

2. FULL NAME

Mahaba Dorsey
(a) Residence. No. *3106 Lucas* St., *24* Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. 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 (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug. 3 1875*

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, ____ hrs. or ____ min.
	<i>52</i>	<i>3</i>	<i>19</i>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *Miss.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Anna Robinson*

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

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

15. FILED *21 25 1927* *Maude Starceoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov. 22, 1927*

17. I HEREBY CERTIFY, That I attended deceased from *11/21*, 19*27*, to *11/22*, 19*27* that I last saw her alive on *11/22*, 19*27*, and that death occurred, on the date stated above, at *9:55 a.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:
Acute Myocardial Infarction

CONTRIBUTORY (SECONDARY) *1290* (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

19. WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*

(Signed) *Red 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 *Greenwood* DATE OF BURIAL *Nov 26 1927*

20. UNDERTAKER *R. M. Shean* ADDRESS *3577 Dale de*

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.

The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry should be supported by a valid receipt or invoice. This ensures transparency and allows for easy verification of the data.

In the second section, the author outlines the various methods used to collect and analyze the data. This includes both manual and automated techniques. The goal is to ensure that the information gathered is both reliable and comprehensive.

The third part of the report details the results of the analysis. It shows a clear upward trend in the data over the period studied. This suggests that the implemented measures are having a positive impact on the overall performance.

Finally, the document concludes with a series of recommendations for future work. It suggests that further research should be conducted to explore additional factors that may influence the results. This will help in refining the current strategies and improving the overall process.