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

Do not use this space.

File No. 35345

Registered No. 19530

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

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

2. FULL NAME Mahala Dorsey

(a) Residence. No. 3106 Lucas 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 10 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Fem.	Col.	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	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	3	19	

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) ..... (STATE OR COUNTRY) Miss.

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Anna Robinson

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

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

15. FILED Nov 25 1927 Mark Starkoff 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, 1927, to 11/22, 1927, that I last saw her alive on 11/22, 1927, and that death occurred, on the date stated above, at 9:55 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Senile Cardiac Nephritis
121
8 yr
Nephritis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 1290 (duration) ..... yrs. ..... mos. ..... ds.

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) Leo C. 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. P. Green — ADDRESS 3547 Laclede Ave

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.