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

Do not use this space.

35444

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 10630

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

City St Louis (No. 3007 Lawton St. ..... Ward)

2. FULL NAME Gertude Smith

(a) Residence. No. 3007 Lawton St., 11 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 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: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

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

7. AGE: Abt 23. Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

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) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY): MO

PARENTS
10. NAME OF FATHER: Alex Caloway
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): UNKMOWN
12. MAIDEN NAME OF MOTHER: UNKMOWN
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): UNKMOWN

14. INFORMANT: Henry Smith
(Address) 3007 LAWTON

15. FILED NOV 27 1927 Max C. Starkloff REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 10-29-1927, to 11-22-1927, that I last saw her alive on 11-22-1927, and that death occurred, on the date stated above, at 1:05 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Aortic Insufficiency Chronic Interstitial Nephritis
131
924 (duration) yrs. 8 mos. ds.

CONTRIBUTORY (SECONDARY): Myocarditis
93 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) E. D. Johnson, M. D.
, 19 (Address) 3201 Franklin Ave.

*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: Washington Park
DATE OF BURIAL: 11/27 1927

20. UNDERTAKER: C W Roberts
ADDRESS: 3035 Lucas

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.