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

Do not use this space.

35619

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 11331

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

2. FULL NAME Ola Mae Sykes

(a) Residence. No. 3156 Easton (R) 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 yrs. 5 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: Col.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): —

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 23, 1927

7. AGE: YEARS | MONTHS 5 | DAYS 4 | If LESS than 1 day, ... hrs. or ..... min.

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)

PARENTS
10. NAME OF FATHER Mathew Sykes
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Miss
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Hattie Simpson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ark
(STATE OR COUNTRY)

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

15. FILED DEC 19 1927, 19 Max B Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 27, 1927

17. I HEREBY CERTIFY, That I attended deceased from 11/27, 1927, to 11/27, 1927 that I last saw her alive on 11/27, 1927, and that death occurred, on the date stated above, at 9:20 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchopneumonia
Secondary
1070
63
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Rickettsia
1000 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? not known

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) L B 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: 12-22-1927

20. UNDERTAKER: R. Aston 2945 ADDRESS: 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.

...IS A PERMANENT RECORD