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

Do not use this space.

38927

1. PLACE OF DEATH

County..... Registration District No. 7-21 File No. 38927

Township..... Primary Registration District No. 1-1-1-93 Registered No. 11668

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

2. FULL NAME Ethelyn Warren

(a) Residence. No. 4009 Clayton St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 11 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)
Female	Negro	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not Known

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt. 39				

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)

PARENTS
10. NAME OF FATHER Samuel Warren
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Miss
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Cortney Caldwell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Miss
(STATE OR COUNTRY)

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

15. DEC 28 1927 FILED..... 19..... Mae B. Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 24 1927

17. I HEREBY CERTIFY, That I attended deceased from December 14 1927, to December 24 1927 that I last saw h. alive on December 24 1927, and that death occurred, on the date stated above, at ..... p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY) Fibroid uterus (operation) Hysterectomy Malignant
(duration) 3 yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? yes DATE OF 12/20/27

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. F. Thomas M. D.

12/26/1927 (Address) City Hospital #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 Washington Park — DATE OF BURIAL 12-28 1927

20. UNDERTAKER Dement & Walton — ADDRESS 2700 Wash

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.