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

Do not use this space.

39098

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 101

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

2. FULL NAME Lelia Wynn Houston

(a) Residence. No. 2131 Randolph St., 22 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 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: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-14-1888

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
39	3	14	

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): Illinois

PARENTS

10. NAME OF FATHER: Chris Wynn.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Not known
12. MAIDEN NAME OF MOTHER: Fannie Mayzell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Not known

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

15. FILED ..... 19.... Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 28 1927

17. I HEREBY CERTIFY, That I attended deceased from December 1 1927, to December 28, 1927 that I last saw her alive on December 28 1927, and that death occurred, on the date stated above, at 5:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Parenchymatous Nephritis I.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (SECONDARY) Fibroma of Cervix undergoing Degeneration (duration) yrs. Indefinite

18. WHERE WAS DISEASE CONTRACTED? Benign

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) J. J. Thomas, M. D

12/28, 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: Greenwood Cem
DATE OF BURIAL: 1-4 1928

20. UNDERTAKER: Peoples Emd Co
ADDRESS: 3100 Franklin

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.