

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

Do not use this space.

2664

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No. **1**

Township.....

Primary Registration District No. **1003**

Registered No. **230**

City **St. Louis**

(No. **914 N. Newcastle**)

St. **1**

Ward **1**

2. FULL NAME

(a) Residence. No. **914 N. Newcastle** 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.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

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 **Pete Turner**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Mar 15 - 1882**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ____ hrs. or ____ min.
	45	9	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **House Work**
(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)

10. NAME OF FATHER **Manuel Reese**

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

12. MAIDEN NAME OF MOTHER **Emma Proctor**

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

14. INFORMANT **Willie Johnson**
(Address) **914 N. Newcastle**

15. FILED **Nov -7 1928** **Mar 6 Starvoeff**
19. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **1-5-1928**

17. I HEREBY CERTIFY, That I attended deceased from **Sept 24** 19**27** to **Jan. 5** 19**28**, that I last saw h. w. alive on **Jan 5** 19**28**, and that death occurred, on the date stated above, at **1132** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

meningitis
121
132 H (duration) **4** yrs. **4** mos. **4** ds.

CONTRIBUTORY (SECONDARY) **Nephritis Chronic** (duration) **Indefinite** da.

18. WHERE WAS DISEASE CONTRACTED **at home**
IF NOT AT PLACE OF DEATH

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

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical & Laboratory**
(Signed) **J. W. Gray, M. D.**
19 (Address) **4390 Easton 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 **1-10-28**

20. UNDERTAKER **W. S. McDonald** ADDRESS **4202 Finney**

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.

