

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

Do not use this space.

3145

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **City Hospital # 2**)..... St. Ward)

File No.....
Registered No. **763**

2. FULL NAME

Mollie Jackson
(a) Residence. No. **1573** **Highgate** St., **22** Ward.

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

2. SEX **Female** 4. COLOR OR RACE **Col.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
70

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Prob. Asst.**
(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) **Indian Territory**

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Eliza Anne Williams**

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

14. INFORMANT (Address) **Wm. J. Woodard City Hospital # 2**

15. FILED **JAN 21 1928** **Room 6 Starckoff** REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan. 20, 1928**

17. I HEREBY CERTIFY That I attended deceased from **Jan. 20, 1928** to **Jan. 20, 1928** that I last saw her alive on **Jan. 20, 1928** and that death occurred, on the date stated above, at **City Hospital # 2**.

THE CAUSE OF DEATH* IS AS FOLLOWS:
Chronic myocarditis
93C

Inde pnt (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **900** (duration) yrs. mos. ds.

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

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

20. WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Chrom**
(Signed) **L. B. Howard** 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 **Washington Park** DATE OF BURIAL **1-21-28**

20. UNDERTAKER **W.S. Wade & Co.** ADDRESS **4202**

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.

PERMANENT RECORD

