

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

Do not use this space.

10723

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1068  
 City St Louis (No. 924 No Newstead).....St. 2554 (Ward)

**2. FULL NAME**

Birdie Lindsey  
 (a) Residence. No. 924 No Newstead St. 11 Ward. (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 OR (OR) WIFE OF Arthur Lindsey

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
abt 43

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

10. NAME OF FATHER Green Deay

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

12. MAIDEN NAME OF MOTHER Hattie Coleman

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

14. INFORMANT (Address) Arthur Lindsey  
924 No Newstead

15. FILED: AP -7 1924 Max G. Starckoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2  
 16. DATE OF DEATH (MONTH, DAY AND YEAR) March 6 1928  
 17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... and that I last saw h..... alive on ..... 19..... and that death occurred, on the date stated above, at..... 11:50 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Myocarditis  
hypertrophic  
heart

CONTRIBUTORY (SECONDARY) hypertrophy of heart  
 (duration)..... yrs. mos. da.

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

8 1290  
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
 WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed) J. W. Turner M.D.  
 , 19..... (Address) W. - Cr

\*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 3/8 1929

20. UNDERTAKER Geo Roberts Under Lucas ADDRESS 3035

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

