

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

Do not use this space.

11788

1. PLACE OF DEATH

County..... Registration District No. **701**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **City Hospital # 2**)

File No.
Registered No. **3676**
.....St.Ward)

2. FULL NAME

(a) Residence. No. **5483 Vernon** St., **5** 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Mar. 16, 1928**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
			8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER **Bertha Hammond**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Mo.**

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

15. **APR - 3 1928** **Max C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Mar. 24, 1928**

17. I HEREBY CERTIFY, That I attended deceased from **276**, 1928, to **324**, 1928 that I last saw her alive on **3/24**, 1928, and that death occurred, on the date stated above, at **6:50 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Status Lymphatic

CONTRIBUTORY (SECONDARY) **67** (duration) yrs. mos. ds.
62 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **From birth**
IF NOT AT PLACE OF DEATH, DATE OF _____

DID AN OPERATION PRECEDE DEATH, DATE OF _____

19. WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**

(Signed) **Dr. Howard**, M.D.
, 19 (Address) **City Hospital # 2**

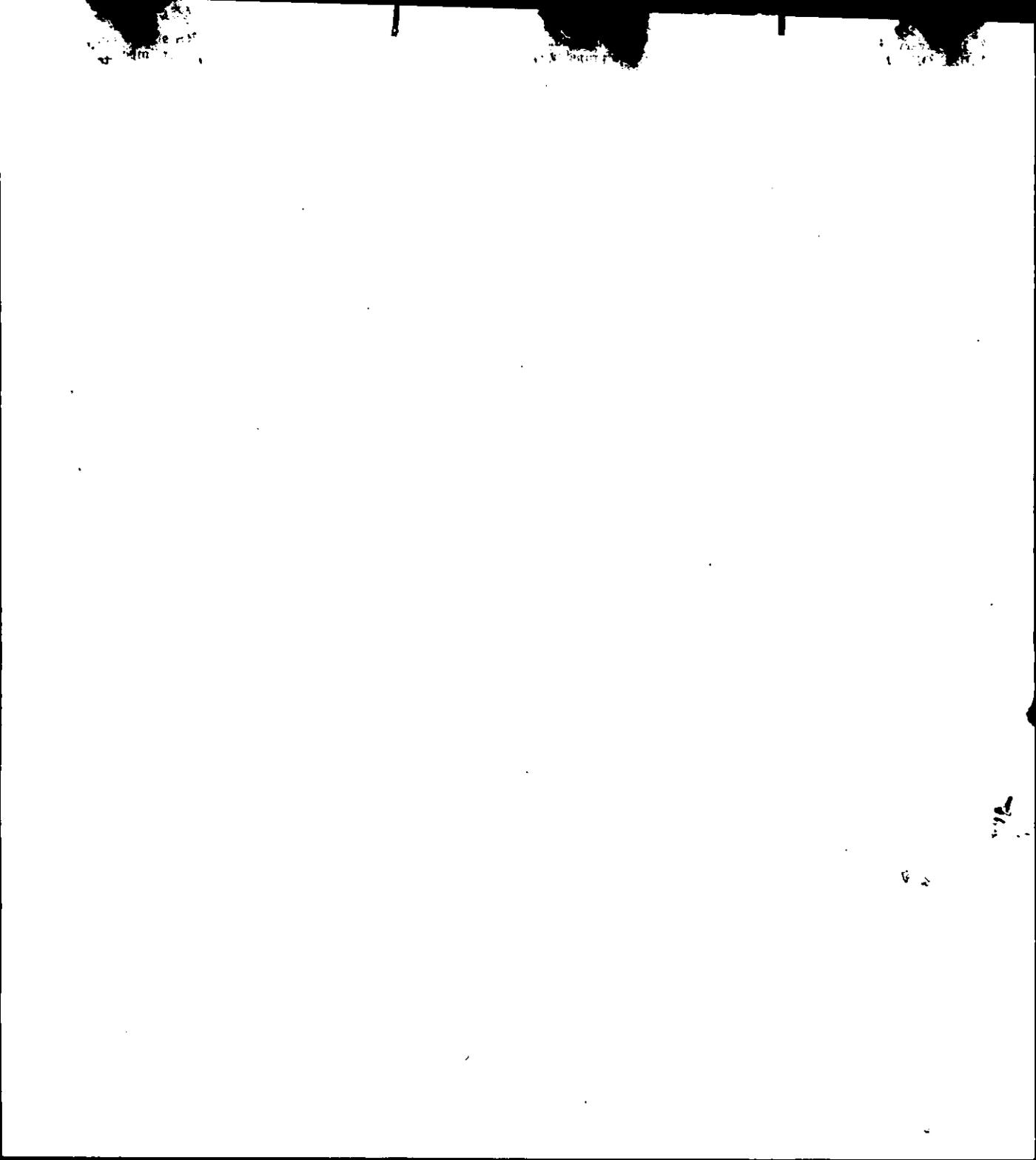
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **POTTERS FIELD** DATE OF BURIAL **4-4-1928**

20. UNDERTAKER **Ray Astor 2945 Lawton** ADDRESS

THIS IS A PERMANENT RECORD

Every item of information should be carefully checked. 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.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No. 991 File No.
 Township..... Primary Registration District No. 1003 Registered No. 3676
 City St. Louis (No.) St. Ward

2. FULL NAME unnamed Hammons

(a) Residence. No. St. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
 (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)

10. NAME OF FATHER Illegitimate

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT ma (Address)

15. Filed JUN 11 1920 Mar. C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 24 1928

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. ds.

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

*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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

RECORDS WILL BE DESTROYED UNLESS THIS IS A PERMANENT RECORD

Every item of information should be carefully examined. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in words is important.

REGISTRATION DISTRICTS ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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