

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

Do not use this space.

15024

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No. *4474*)

Registration District No. *791*
Primary Registration District No. *1003*

File No.
Registered No. *3940* St. Ward

2. FULL NAME

(a) Residence. No. *4474 Fairfax Ave. 11* Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Colored* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (specify the word) *Widower*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown 1850*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>abt</i>	<i>78</i>			

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) *Tracy, Missouri*
(STATE OR COUNTRY)

10. NAME OF FATHER *Horace Fair*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Richmond, Virginia*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Mrs. Madisson*
(Address) *4474 Fairfax Ave. St. Louis*

15. FILED *APR 10 1923* REGISTRAR *W. C. Daniel*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 7th 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Dec. 3rd 1927*, to *April 6th 1928*, 19 *28* that I last saw *her* alive on *April 6th 1928* and that death occurred, on the date stated above, at *6:00 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Asthma - (patient had ever had tried to eat drop of potatoes before going to bed.)

CONTRIBUTORY *Dilatation of left ventricle* (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED *93 B 1722*

IF NOT AT PLACE OF DEATH..... DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Weston Clinical W. R. Williams, M. D.*
(Signed) *W. R. Williams*, M. D.
, 19 (Address) *823 - 4416²*

*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 *4/10 1928*

20. UNDERTAKER *Funeral Undertaking Co.* ADDRESS *4057 Finney*

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.

