

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

Do not use this space.

15519
15250

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 003
City St. Louis (No. City Hospital #2)
St. _____ Ward)

2. FULL NAME

(a) Residence. No. 3011 A Wickham St., 21 Ward. (If nonresident give city or town and State)
Length of residence in city or town where death occurred 9 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 Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-12-1902

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ___ hrs. or ___ min.
25 | 11 | 9 | =

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work maid
(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) Ark.

10. NAME OF FATHER William Cochrane

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

12. MAIDEN NAME OF MOTHER Maria English

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

14. INFORMANT (Address) Mrs. F. W. Padash
City Hospital #2

15. FILED FR 24 1928 Mar C. Farkley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 21 1928

17. I HEREBY CERTIFY That I attended deceased from April 9 1928, to April 21 1928 that I last saw her... alive on April 21 1928, and that death occurred, on the date stated above, at 3:00 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Diffuse Peritonitis.

CONTRIBUTORY (SECONDARY) Ruptured Tubercular Abscess of Spleen

18. WHERE WAS DISEASE CONTRACTED? St. Louis

19. DATE OF OPERATION PRECEDES DEATH? yes DATE OF 4/20/28

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? City Hospital Laboratory

(Signed) J. P. Thomas M.D. 4/23 1928 (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 Marianna Ark DATE OF BURIAL 4/25 1928

20. UNDERTAKER C. W. Roberts 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.

