

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

Do not use this space.

17328

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township 1st Primary Registration District No. 100
 City St. Louis (No. 101)

File No. _____
 Registered No. 2301
 St. _____ Ward _____

2. FULL NAME

(a) Residence No. 2982 Wood 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jul 17 1881

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
about 40 10 5

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) (STATE OR COUNTRY) N.C. Va.

10. NAME OF FATHER Tom Davis

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

12. MAIDEN NAME OF MOTHER Smart Moore

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

14. INFORMANT Sarah Jones
 (Address) 1472 N. Southern St

15. FILED 5735-28 1928
St. Louis REGISTRAR M. M. Crowe

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-17-28

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Subacute Tuberculosis
from insignifant
 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) 139
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS autopsy
 (Signed) Dr. Turner M. D.
 17/5/19 (Address) Deputy Coroner

*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 St. Louis DATE OF BURIAL 5/20 1928

20. UNDERTAKER St. Louis ADDRESS City

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.

