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

Do not use this space.

19309

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 5742

City St. Louis (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Pearl Troupet

(a) Residence. No. 3134 La Salle St., 18 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... 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*): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 7, 1900

7. AGE: Years 28 | Months 4 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(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): Ga.

PARENTS

10. NAME OF FATHER: Robert Jordan
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ga.
12. MAIDEN NAME OF MOTHER: Molesta Godfrey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ga.

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

15. FILED MAY 28 1928, 19 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 22, 1928

17. I HEREBY CERTIFY, That I attended deceased from 4/7, 1928, to 5/22, 1928 that I last saw her alive on 5/22, 1928, and that death occurred, on the date stated above, at 12:35 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
230
about (duration) yrs. 6 mos. ds.

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

31

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? not known
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) L. L. Howell, M. D.
, 19 (Address) City Hosp #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: Greenwood Cemetery
DATE OF BURIAL: May 28 1928

20. UNDERTAKER: J. C. Thomas
ADDRESS: 2111 Laclede

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.

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