

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

Do not use this space.

19356

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **City Hospital #2**) St. _____ (Ward)

File No. _____
 Registered No. **5796**

2. FULL NAME

(a) Residence. No. **1916 Morgan** St., _____ Ward, _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred **6** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 **Chat Carnack**

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
abt. 36 | **Unknown** | |

8. OCCUPATION OF DECEASED.
 (a) Trade, profession, or particular kind of work **Mail**
 (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 **Miss Robert Pinell**

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

12. MAIDEN NAME OF MOTHER **Miss Phyllis Unknown**

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

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

15. FILED **29 1935** **May E. Starbuck** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 26, 1928**

17. I HEREBY CERTIFY, That I attended deceased from **5/23** 19**28**, to **5/26** 19**28**, that I last saw **her** alive on **5/26** 19**28**, and that death occurred, on the date stated above, at **5:45 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage
about 5/26/28
 (duration) yrs. mos. da. **6 da.**
 CONTRIBUTORY (SECONDARY) **Hypertension**
 (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? **no** DATE OF _____

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **clinical**
 (Signed) **W. S. Wade**, M. D.

*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 **Crystal Springs Miss** DATE OF BURIAL **5/30 1928**

20. UNDERTAKER **W. S. Wade** ADDRESS **4202 Finney**

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.

RECORD WITH UNFADING INK—THIS IS A PERMANENT RECORD

