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

Do not use this space.

19379

1. PLACE OF DEATH

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

Township ..... *Primary Registration District No. 1003 ..... Registered No. 5819

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

2. FULL NAME Carrie Miller

(a) Residence. No. 2720 Morgan St., 25 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. 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-18-1886

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
42	2	8	

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) Miss.

PARENTS

10. NAME OF FATHER General Washington

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

12. MAIDEN NAME OF MOTHER Dorothy Hines

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

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

15. FILED MAY 29 1928 Max C. Starkey 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 May 12, 1928, to May 26, 1928 that I last saw her alive on May 2[illegible], 1928, and that death occurred, on the date stated above, at 8:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uterine Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (SECONDARY) Fibromyoma of uterus multiple non Malignant (duration) yrs. 3 mos. ds.

18. WHERE WAS DISEASE CONTRACTED 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) J. J. Thomas, M.D.

5/28/, 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: Washington Park

DATE OF BURIAL: June 3 1928

20. UNDERTAKER: W. C. Gordon Und Co

ADDRESS 3649 Morgan

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.