

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

Do not use this space.

21898

**1. PLACE OF DEATH**

County.....  
Towship.....  
City.....

Registration District No. **791**  
Hospital District No. **1003**  
Hospital No. **2**

File No. ....  
Registered No. **6019**  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **123** **St. Clair** St., **18** Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred **75** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Female** 4. COLOR OR RACE **Col.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**abt. 86** ? ?

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Nil**  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Mo.**  
(STATE OR COUNTRY)

10. NAME OF FATHER **Edward Curry**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

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

15. FILED **CLN - 5 1928**  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 1, 1928**  
17.

I HEREBY CERTIFY That I attended deceased from **5/28** 1928, to **6/1** 1928, and that I last saw him alive on **5/28** 1928, and that death occurred, on the date stated above, at **8:15 P.** m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Cerebral apoplexy**  
**Short** (duration) yrs. mos. da. **5**

CONTRIBUTORY (SECONDARY) **Hypertension**  
(duration) yrs. mos. da.

WHERE WAS DISEASE CONTRACTED **Not known**  
IF NOT AT PLACE OF DEATH

DID ANY OPERATION PRECEDE DEATH? **NO** DATE OF

WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**  
(Signed) **Dr. Houder** M. D.  
, 19 (Address) **City Hospital #2**

\*State the DISEASE CAUSING DEATH, or in death 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 **6/5 1928**

20. UNDERTAKER **Wm. Bros** ADDRESS **215 S. Jefferson**

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.

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