

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

Do not use this space.

22404

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... City Registration District No. 002
 City St. Louis (No. City Hospital #2)..... St. 6590 Ward 26

2. FULL NAME

(a) Residence. No. 1617 Maple St. 26 Ward. (If nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred 2 1/2 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Col.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 2, 1874</u>		
7. AGE	YEARS <u>57</u>	MONTHS <u>2</u>
	DAY <u>17</u>	IF LESS than 1 day, <u> </u> hrs. or <u> </u> min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>housework</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 19, 1928
 17. I HEREBY CERTIFY that I attended deceased from 5/16, 1928, to 6/19, 1928 that I last saw her alive on 6/19, 1928, and that death occurred, on the date stated above, at St. Louis, Mo.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Chronic myocarditis
with SOB
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY)
 (duration) yrs. mos. ds.

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

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

15. FILED 20 1928 Maple St. Louis REGISTRAR

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

DID AN OPERATION PRECEDE DEATH? no DATE OF
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) W. O. Gordon, M. D.
 , 19 (Address) City Hosp. #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 Father Dickson Cem. DATE OF BURIAL 6/24 1928

20. UNDERTAKER W. O. Gordon Und. Co ADDRESS 2649 Morgan St

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

