

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

22626

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **6555**)

File No.

Registered No.

St. Ward)

2. FULL NAME

(a) Residence. No. **1623 S. Second** St., **23** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **10** yrs. **1** 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) **single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **10-15-1912**

7. AGE YEARS **15** MONTHS **8** DAYS **12** If LESS than 1 day, hrs. or min.

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) **Kenton**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Traskboro Ala** (STATE OR COUNTRY)

10. NAME OF FATHER **Lidney Sanders**

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

12. MAIDEN NAME OF MOTHER **Gertrude Briggs**

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

14. INFORMANT **Gertrude Harris** (Address) **1023 S. Second St.**

15. FILED **1928** **Max C. Stankler** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6-27-1928**

17. I HEREBY CERTIFY That I attended deceased from **6-18-1928** to **6-27-1928** that I last saw **her** alive on **6-27-1928** and that death occurred, on the date stated above, at **3 27 a.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Double Lobar Pneumonia
162
1948/6/17 (duration) yrs. mos. **9** da.

CONTRIBUTORY exposure (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **at place of death** IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH? **NO** DATE OF

20. WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS **none** (Signed) **Wm. William Johnson, M.D.**

(Address) **4039a Finney**

*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** DATE OF BURIAL

20. UNDERTAKER **Be Leonard** ADDRESS

