

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1008**

City *St. Louis, Mo.* (No. *5600*, *Arsenal*)

File No. **25496**
Registered No. **7310**
St. *24th* Ward

2. FULL NAME

(a) Residence. No. *1810 Papin* St., *22* Ward.
(Usual place of abode)

Length of residence in city or town where death occurred *5* yrs. *?* mos. *?* ds.

(If nonresident give city or town and State)
How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Lena Mc Cowan

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

Aug. 2nd 1903

7. AGE

YEARS *24*

MONTHS *11*

DAYS *None*

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Laborer

(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)

Tennessee

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

not known

14.

INFORMANT

(Address)

Lena Mc Cowan

1810 Papin

15.

FILED

JUL 14 1928

Wm C Starck

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

7/11 19*28*

17.

I HEREBY CERTIFY That I attended deceased from *7/11*, 19*28*, to *7/11*, 19*28*, that I last saw h. *alive* on *7/11*, 19*28*, and that death occurred, on the date stated above, at *4:45 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Epidemic Cerebrospinal Meningitis
18 (duration) yrs. mos. ds.
131 *chron. Nephritis*

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

1810 Papin St.

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *Cuth. H. White* M. D.
7/13, 1928 (Address)

ISOLATION HOSPITAL

*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

DATE OF BURIAL

Memphis, Tenn

7-14 1928

20. UNDERTAKER

ADDRESS

E Scott 3015. Lawton, Tenn

WRITE PLAINLY, WITH UNFADING INK---THIS IS PERMANENT RECORD

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.

OK
OK