

**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. **701**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *1318 1/2 St*)

File No. **25663**
Registered No. **7480**
St. _____ Ward _____

2. FULL NAME

Carrie Jamerson

(a) Residence. No. *1318 1/2 St* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *1897-3-4*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
31 | 4 | 12

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) *132A 21B 95B*
(c) Name of employer

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

10. NAME OF FATHER *Robert Milton*

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

12. MAIDEN NAME OF MOTHER *Mary Perkins*

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

14. INFORMANT *Corrie Jamerson*
(Address) *1318 1/2 St*

15. FILED *20 1923* *Ray C. Starkey* REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 16 1928*

17. I HEREBY CERTIFY, That I attended deceased from *July 16 1928* to *July 16 1928*, and that I last saw him alive on *July 16 1928*, at *3-9* m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Subarachnoid hemorrhage
900 from history (duration) yrs. mos. da. *10*
CONTRIBUTORY (SECONDARY) *Septic Dilatation of heart* (duration) yrs. mos. da. *9*

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

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

19. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Physicist + Lab Exam*
(Signed) *Archibuthan* M. D.
, 19 (Address) *11 N. Jefferson*

*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 *July 21 1928*

20. UNDERTAKER *A. L. Beal* ADDRESS *2726 Lucas*

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.

PERMANENT RECORD

