

**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. 782

Township.....

Primary Registration District No. 1000

City St Louis MO

No. 713 Rear Carr St. 25 Ward

File No. 25972

Registered No. 7886

St.

Ward)

**2. FULL NAME**

(a) Residence. No. 713 Rear Carr 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 7 yrs. mos. da.

How long in U.S., if of foreign birth? yrs. mos. ds.

**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) 9/11/1925

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, hrs. min.

2

10

16

8. OCCUPATION OF DECEASED

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

mil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St Louis

(STATE OR COUNTRY)

MO

10. NAME OF FATHER

Sam Turner

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Monroe

(STATE OR COUNTRY)

La

12. MAIDEN NAME OF MOTHER

Leola Greer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Texarkana

(STATE OR COUNTRY)

Texas

14.

INFORMANT

(Address)

Sam Turner

713 Rear Carr St

15.

FILED

11 30 1928

May C. Stanley

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/27 1928

17.

I HEREBY CERTIFY, That I attended deceased from 7-24 1928, to 7-27 1928

that I last saw her alive on 7-27 1928, and that death occurred, on the date stated above, at 11:00 P

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Broncho Pneumonia  
Primary  
107A 100A  
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY)

Broncho Pneumonia  
Primary  
(duration) yrs. mos. 6 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

Unknown

0 Did an operation precede death? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

Symptoms

(Signed) L. J. Vincent

M. D

, 19

(Address)

239<sup>th</sup> So. Jefferson

\*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

DATE OF BURIAL

Washington Park Cemetery

7/31/ 1928

20. UNDERTAKER

ADDRESS

Rumm Bros

215<sup>th</sup> Jefferson ave

ENCLOSING INK-- THIS IS A 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.

