

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No. **28492**
Registered No. **7918**
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. **1115 So. Cardinal** St., _____ 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 **Col** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 30 - 1928**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
— — 2

8. OCCUPATION OF DECEASED

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

PARENTS

10. NAME OF FATHER **Notice Shaw**

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

12. MAIDEN NAME OF MOTHER **Helen Jones**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Missouri**

14. INFORMANT **Notice Shaw** (Address) **1115 So. Cardinal**

15. FILED **1115 So. Cardinal** REGISTAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July Aug - 1 1928**

17. I HEREBY CERTIFY, That I attended deceased from **July 30th** to **July 30th** 1928, and that I last saw her alive on **July 30th**, and that death occurred, on the date stated above, at **3:15 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage at Birth

16013 (duration) **161 B** yrs. mos. da.

CONTRIBUTORY (SECONDARY) **X** (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? **No.** DATE OF **X** WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) **D. V. Roberts**, M. D.

*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 **Father's home** DATE OF BURIAL **8-1 1928**

20. UNDERTAKER **Waters and Son, Lhouveau** ADDRESS **2941**

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.

