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 ..... File No. 28659

Township ..... Primary Registration District No. 1025 ..... Registered No. 8116

City St. Louis (No. Deaconess Hospital St. ..... Ward)

2. FULL NAME Nancy Todd

(a) Residence. No. 7465 North Broadway 8 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 16, 1848

7. AGE: Years 80 | Months 1 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(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): Nashville Tenn

PARENTS

10. NAME OF FATHER: John Jackson
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: Mrs. Rose Ford
(Address) 7465 North Broadway

15. FILED 6-9 1928 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from July 17, 1926, to Aug 7, 1928, that I last saw her alive on Aug 7 1928, and that death occurred, on the date stated above, at 11 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Nephritis Chronic
1 2 3 4 5 6 7 8 9 10 11 12 1 2 9 a
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Myocarditis Chronic
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) M. J. Davis, M. D
, 19 (Address) 3602 W Florissant

*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: Bellefontaine
DATE OF BURIAL: Aug 10 1928

20. UNDERTAKER: Math. Hermann and Son
ADDRESS: 3950 Carter Ave

WHITE PLAINLY, WITH UNFADING 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.