

**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

Towship.....

Primary Registration District No.....

1003

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

File No.....

28678

Registered No.....

8138

St. *24th* Ward)

2. FULL NAME

Vera Hamilton

(a) Residence. No. *3054 Cass* St., *21* Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. *1* mos. *3* ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | *Colored* | *Single*

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

single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 3, 1924*

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<i>4</i>	<i>1</i>	<i>3</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *none*

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis, Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Robert Hamilton*

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

12. MAIDEN NAME OF MOTHER *Lovane Outlay*

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

14. INFORMANT *Mrs. Lovane Hamilton*
(Address) *3054 Cass Ave.*

15. FILED *2 22 19 28* *Marl Standley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 6 19 28*

17. I HEREBY CERTIFY That I attended deceased from *Aug 5 (10 p.m.) 28* to *Aug 6 (12:55 p.m.) 28* that I last saw him alive on *Aug 6 12:55 p.m.* and that death occurred, on the date stated above, at *12:55 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diphtheria, Pharyngeal & Nasal
Myocarditis, Acute Diphtheritic
(duration) *0* yrs. *0* mos. *1* ds.

CONTRIBUTORY (SECONDARY) *Myocarditis, Acute Diphtheritic*
(duration) *0* yrs. *0* mos. *1* ds.

18. WHERE WAS DISEASE CONTRACTED *3054 Cass*
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF OPERATION.....

20. WAS THERE AN AUTOPSY? *No* YES ()

WHAT TEST CONFIRMED DIAGNOSIS *Physical & Laboratory*
(Signed) *Joseph Harrison* M. D.

(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 *Greenwood* DATE OF BURIAL *Aug 10 19 28*

20. UNDERTAKER *Rememberson* ADDRESS *2700 Wash St*

X. 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.

WHILE IN PRINT, WITH IMPROVING INK—THIS IS A PERMANENT RECORD

Handwritten text, possibly a signature or name, oriented vertically. The text is extremely faint and difficult to decipher, but appears to contain several lines of cursive script.