

**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..... File No. **29094**
 Township..... Primary Registration District No. **5070** Registered No. **8802**
 City **St. Louis, Mo.** No. **City Hospital # 2** St. (Ward)

2. FULL NAME

Naomi Baldwin
 (a) Residence. No. **3020 Franklin St.** **21** Ward. (If nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. **2** mos. **16** da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* **4. COLOR OR RACE** *Colored* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *Single*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 6, 1928*
7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
0 2 16
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Nil*
 (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) *St. Louis, Mo.*
10. NAME OF FATHER *Robert Baldwin*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Alabama*
12. MAIDEN NAME OF MOTHER *Georgia Love*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Arkansas*

14. INFORMANT (Address) *P. Sexton City Hospital # 2*
15. FILED *NOV 21 1928* *W. C. Stanley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8-22-28*
17. I HEREBY CERTIFY, That I attended deceased from *8-21-28*, 19*28*, to *8-22-28*, 19*28*, that I last saw him *alive* on *8-22-28*, 19*28*, and that death occurred, on the date stated above, at *6:30 A. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho pneumonia
Primary
107A
 (duration) yrs. mos. *4* da.
CONTRIBUTORY (SECONDARY) *107A*
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____
19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____
WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *J. S. Cunningham, M. D.*
 , 19 (Address) *2945 Belmont*

*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** *8-25-28*
20. UNDERTAKER *C. W. Roberts* **ADDRESS** *3035 Duca*

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.

