

MISOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

32131

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis Mo*

Registration District No. *791*
Primary Registration District No. *1003*
No. *6130* *Plymouth Ave.*

File No.....
Registered No. *9482*
St..... Ward.....

2. FULL NAME

(a) Residence. No. *6130 Plymouth St.* *5* 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. *1* mos. *5* 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) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Samuel W. Patterson*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov. 25-1873*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 *9* *27*

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Housewife*
(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) *Kentucky*

10. NAME OF FATHER *Wm L. Burris*

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

12. MAIDEN NAME OF MOTHER *Stokes*

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

14. INFORMANT *Mrs B. B. Burris*
(Address) *6130 Plymouth*

15. FILED *Max C. Stanley*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept - 22 1928*
17. I HEREBY CERTIFY That I attended deceased from *Sept 10th* 1928 to *Sept 22 1928* that I last saw her alive on *Sept 22* 1928, and that death occurred, on the date stated above, at *5 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute endocarditis
10/10
CONTRIBUTORY *Laber Pneumonia*
(SECONDARY) (duration) yrs. mos. *10* 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.....
(Signed) *J. N. Bart*, M. D.
9/23 1928 (Address) *6123 Easton*

*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 *Sparta Ill* DATE OF BURIAL *Sept 24 1928*

20. UNDERTAKER *Ciker & Sons Und.* ADDRESS *Sparta Ill*

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.

PERMANENT RECORD

