

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

Do not use this space.

**32135  
9486**

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City St Louis (No. 6/05) Pennsylvania St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 6/05 Pennsylvania 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 13, 1883  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
45 | 8 | 6 | 0 | 0 | 0  
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)**

Missouri  
**10. NAME OF FATHER** Luther K. Baker  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** Missouri  
**12. MAIDEN NAME OF MOTHER** Martha Sweetser  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** Missouri

**14. INFORMANT** Christopher G. Black  
(Address) 6/05 Pennsylvania

**15. FILED** 21 1928 MA W 10 11  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sep 19 1928  
17. I HEREBY CERTIFY, That I attended deceased from Sep 2 1928 to Sept 19 1928 that I last saw her alive on Sep 19 1928 at 9:45 P. and that death occurred, on the date stated above, at 9:45 P.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
1379 1928 1928 1928  
Alveolar Heart Disease  
Cholera (duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) Cholera (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?  
(Signed) Samuel Stafford M. D.  
9-20-1928 (Address) 925 N. Jefferson Ave

\*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** Oak Dale **DATE OF BURIAL** 9-24-1928

**20. UNDERTAKER** A. Russell and Co **ADDRESS** 2732 Pine St

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.

RECORD

PERMANENT

