

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

Do not use this space.

32389

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

City Registration District No. **1003**

City **St. Louis** (No. **City Hospital # 2**)

File No.....

Registered No. **9789**

St. Ward)

2. FULL NAME

(a) Residence. No. **5 Locust** St., **257** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **15** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

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

Unknown

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, hrs. or min.

abt. 40

?

?

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

domestic

(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)

Okla.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14.

INFORMANT

(Address)

**Anna J. Woodard
City Hospital # 2**

15.

FILED

CT - 5 1928

REGISTRAR

Mary E. Starck

MEDICAL CERTIFICATE OF DEATH

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

9-28-1928

17.

I HEREBY CERTIFY That I attended deceased from **9-27-1928** to **9-28-1928** that I last saw her alive on **9-28-1928**, and that death occurred, on the date stated above, at **7:30 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

lobar pneumonia

102

101A

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS? **Post-mortem**

(Signed) **T. C. Cunningham, M. D.**

, 19 (Address) **2945 Jackson**

*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

DATE OF BURIAL

Washington Park Cemetery Oct 3 1928

20. -UNDERTAKER

ADDRESS

Peoples Und. Co. Frankh

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.

