

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

Do not use this space.

35390

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 1003
City Hospital # 2

File No.....
Registered No. 10289
St. Ward)

2. FULL NAME

(a) Residence No. 1637 S. 3d St., 73 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 Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 24, 1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, <u>2</u> hrs. or <u>25</u> min.
				<u>159</u>

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(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 Frank Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN; STATE OR COUNTRY) Ill.

12. MAIDEN NAME OF MOTHER Evelyn Poze

13. BIRTHPLACE OF MOTHER (CITY OR TOWN; STATE OR COUNTRY) Miss.

14. INFORMANT (Address) Anna J. Woodard City Hospital # 2

15. FILED OCT 24 1928 John B. Starker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-21-1928

17. I HEREBY CERTIFY, That I attended deceased from 10-21 11:25 A.M., 1928, to 10-21-4:00 A.M., 1928 that I last saw h. 2 alive on 10-21-1928, and that death occurred, on the date stated above, at 4:00 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pre-mature Birth

CONTRIBUTORY (SECONDARY) Halt (duration) 2 hrs. 35 min.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS. (Signed) T. E. Cunningham, M. D. (Address) 2945 Stanton

*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 POTTERS FIELD DATE OF BURIAL OCT 25 1928

20. UNDERTAKER P. Aston 2945 Stanton ADDRESS

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.

