

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

Do not use this space.

**43397**

**1. PLACE OF DEATH**

County.....

Registration District No. 791

Township.....

Primary Registration District No. 7003

City St. Louis

No. 1

City Hospital #2

File No. ....

Registered No. 12709

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 1212 Franklin St. 25 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 25, 1900

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<u>28</u>	<u>6</u>	<u>22</u>	

**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) Tenn.

**10. NAME OF FATHER**

Wm. Hicks

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Tenn.

**12. MAIDEN NAME OF MOTHER**

Tina Scott

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Tenn.

**14. INFORMANT**

(Address) City Hospital #2

**15. FILED**

27 1928

19

Max O. Starny  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-17-1928

17. I HEREBY CERTIFY, That I attended deceased from 12-14-1928, to 12-17-1928, that I last saw her alive on 12-17-1928, and that death occurred, on the date stated above, at 4:30 A. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Broncho-Pneumonia  
1928

**CONTRIBUTORY (SECONDARY)**

**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. G. Cunningham, M. D.

, 19 (Address) 1945 Sawton

\*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**

Greenwood Cemetery

12/27 1928

**20. UNDERTAKER**

Dunn Bros

**ADDRESS**

215 1/2 Jefferson ave

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.

WRITE FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

