

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

Do not use this space.

F8

43654-77

**1. PLACE OF DEATH**

County.....  
Township.....  
City, St. Louis (No. City Hospital #2)

Registration District No. 791  
Primary Registration District No. 1003

File No.....  
Registered No. 388  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 1910 Morgan St., M Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S., if of foreign birth 1 yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Col.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Bernice Duke</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 26, 1902</u>		
7. AGE	YEARS <u>26</u>	MONTHS <u>4</u>
	DAYS <u>4</u>	If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Onion  
(STATE OR COUNTRY) Miss

10. NAME OF FATHER Alex Nickelson

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

12. MAIDEN NAME OF MOTHER L. Alford

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

14. INFORMANT Anna H. Upward  
(Address) City Hospital #2

15. FILED -8 W. E. Staker  
REGISTRAR

**1 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-30-1928

17. I HEREBY CERTIFY, That I attended deceased from 12-28-1928 to 12-30-1928, 1928 that I last saw her alive on 12-30-1928, and that death occurred, on the date stated above, at 4:00 A.M.

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

23A

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 31

(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 X-ray & sputum

(Signed) H. C. Cunningham, M. D.

, 19 (Address) 2945 Hawthorn

\*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 Father Dickson DATE OF BURIAL 1-8-1929

20. UNDERTAKER A. E. Walter ADDRESS 2701 Stoddard

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.

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