

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

Do not use this space. 4807

1. PLACE OF DEATH

County..... Registration District No. 1004
 Township..... Primary Registration District No. 1004
 City St. Louis, No. 1517a S. 39th st. Registered No. 1500 St. _____ Ward)

2. FULL NAME Grace Wooten,

(a) Residence. No. _____ St. 17 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Walter C. Wooten,				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1871-11-11				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	57	2	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **At home**
 (b) General nature of industry, business, or establishment in which employed (or employer) **Housewife**
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Memphis,**
 (STATE OR COUNTRY) **Tenn.**

PARENTS

10. NAME OF FATHER **Jos. Turner,**

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

12. MAIDEN NAME OF MOTHER **Elizabeth Unk.**

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

14. INFORMANT Wall C. Wooten
 (Address) 1517a S. 39th st.

15. FILED 21 1929 May C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **January 30 1929**

17. I HEREBY CERTIFY That I attended deceased from **Jan. 25th 1929** to **January 30 1929** and that I last saw him alive on **January 26th 1929**, and that death occurred, on the date stated above, at **4:30 A.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis,

90B (duration) yrs. mos. **5** da.
 CONTRIBUTORY: **Asthma.** (SECONDARY) (duration) yrs. mos. **5** da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS.....
John A. Kelly M. D.

1/30/1929 (Address) **3867 Detonty st.**

*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 **Valhalla** DATE OF BURIAL **1/31 1929**

20. UNDERTAKER **Robert J. ...** ADDRESS **429 N. ...**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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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