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

Do not use this space.

8277

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

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

File No. .....

Registered No. 1926

2. FULL NAME Malinda Cochran

(a) Residence. No. 4215 Garfield St., 11 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 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): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 25, 1876

7. AGE: Years 52 | Months 1 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Factory 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): Miss.

PARENTS

10. NAME OF FATHER: Sam Whitfield
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): N. Car.
12. MAIDEN NAME OF MOTHER: Mariah Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): N. Car.

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

15. FILED 11 1929, 19 Max C. Starkeff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-7- 1929

17. I HEREBY CERTIFY, That I attended deceased from 1-16- 1929 to 2-7- 1929 that I last saw her alive on 2-7- 1929 and that death occurred, on the date stated above, at 7:15 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chr. nephritis c
Chr. myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Acute multiple arthritis (duration) yrs. 1 mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 131
IF NOT AT PLACE OF DEATH? 0
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Sob

(Signed) T. E. Cunningham, M.D.
, 19 (Address) 2945 Fawton

*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: Greenwood
DATE OF BURIAL: 2-11- 1929

20. UNDERTAKER: W. S. Wade
ADDRESS 4202 Finney 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.