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

Do not use this space.

8319

1. PLACE OF DEATH

County ..... Registration District No. 791 ~~1003~~

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

City St. Louis (No. 2221 a. Morgan St. ..... Ward)

File No. .....

Registered No. 1971

2. FULL NAME Maggie Davis

(a) Residence. No. ..... St., 21 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Fem	Col'd	Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 1, 1870

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
~~Abt~~	58	11	6	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Kentucky

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known

14. INFORMANT Lulu Rafferty
(Address) 2221 a Morgan

15. FILED FEB 11 1929 19 Max C Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 2-6, 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 12 10 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gangrene of left foot & leg 57

57 (duration) 960 yrs. mos. 15 ds.

CONTRIBUTORY (SECONDARY) Diabetes Mellitus Indefinite (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? Urinalysis

(Signed) T. L. Walker, M. D

2/8, 1929 (Address) 808 N Jefferson Ave

*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 Washington Park

DATE OF BURIAL Feb. 12 1929

20. UNDERTAKER S H Harrison

ADDRESS 2906 Lawton

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.

235

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31