

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

Do not use this space.

8650

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 7003
 City St Louis Mo (No. 2127) Walnut St. _____ Ward _____
 Registered No. 2521

2. FULL NAME

Mannie Joe Willis
 (a) Residence. No. 2127 Walnut St. 23 Ward _____
 (Usual place of abode)

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. (If nonresident give city or town and State)

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 Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9/6/1922

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>6</u>	<u>5</u>	<u>13</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work at School
 (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) Ark

10. NAME OF FATHER James Willis

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

12. MAIDEN NAME OF MOTHER Eona Stephenson

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

14. INFORMANT James Willis
 (Address) 2127 Walnut St

15. FILED FEB 20 1929 W. C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 19. 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1929 to Feb 19 1929 that I last saw her alive on Feb 19 1929 and that death occurred, on the date stated above, at 6:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia

108 / 1010W (duration) yrs. mos. ds. 7

CONTRIBUTORY (SECONDARY) 1010W (duration) yrs. mos. ds.

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.....
 (Signed) Walpung M. D.
 , 19 (Address) 5011 1/2 Market

*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 Cemetery DATE OF BURIAL 2/21 1929

20. UNDERTAKER Dunn Bros ADDRESS 2152 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.

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