

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

Do not use this space.

8703

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St Louis (No. 2142) Clark Ave St. _____ Ward _____

2. FULL NAME

Ada Corlham
 (a) Residence. No. 2142 Clark 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 1 yrs. 7 mos. 2 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Calad 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 16 1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	1	7	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Wife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St Louis
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER James Corlham

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

12. MAIDEN NAME OF MOTHER Matilda Jackson

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

14. INFORMANT James Corlham
 (Address) 2142 Clark Ave

15. FILED 21 10 1929
 REGISTRAR W. C. Miller

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 18 1929

17. I HEREBY CERTIFY That I attended deceased from Feb 12, 1929, to Feb 18, 1929, that I last saw her alive on Feb 27, 1929, and that death occurred, on the date stated above, at 2:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis

3/23A
3/62
 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) Richets
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____
 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Physiocal
 (Signed) W. C. Miller M. D.

*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.
1446 S Grand

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Washington Park DATE OF BURIAL Feb 21 1929

20. UNDERTAKER J W Hughes ADDRESS 2620 Lanton

K. 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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2
2

