

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

Do not use this space.

12722

1. PLACE OF DEATH

County..... Registration District No. 781
 Township..... Primary Registration District No. 5003
 City St. Louis (No. 1245 Carr St.) St. _____ Ward _____

File No. _____
 Registered No. 3257

2. FULL NAME

Emma Clayton
 (a) Residence No. 1245 Carr St., 25 Ward.
 (Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not Known

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt. 43 - - -

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Laundress
 (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) Georgia

10. NAME OF FATHER Henry Craddock

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

12. MAIDEN NAME OF MOTHER Laura Anderson

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

14. INFORMANT Hiram Clayton
 (Address) 1245 Carr St

15. FILED 15 1929 Max C. Parker REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar, 12 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar, 7 1929, to Mar, 12 1929 that I last saw her alive on Mar, 12 1929, and that death occurred, on the date stated above, at 3:50 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Subar pneumonia
108 / 101 (duration) yrs. mos. 4 ds.
 CONTRIBUTORY (SECONDARY) Cold non specific (duration) yrs. mos. 7 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? auscultation
 (Signed) J. A. Flowers, M. D.

3/12 1929 (Address) 1711 N. 10th 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 Greenwood DATE OF BURIAL Mar. 18 1929

20. UNDERTAKER J. 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.

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