

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

Do not use this space.

13127

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City, St. Louis, (No. 4440 Maffitt Avenue St. Ward)

File No. 5687
 Registered No.

2. FULL NAME Georgia Penny

(a) Residence. No. 4440 Maffitt 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 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 Negro	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 7, 1907

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	21	9	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework
 (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) Missouri

10. NAME OF FATHER Arthur Penny

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

12. MAIDEN NAME OF MOTHER Susie Townsend

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

14. INFORMANT Susie Penny
 (Address) 4440 Maffitt Avenue

15. FILED 26 W. C. Starker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 23 1929

17. I HEREBY CERTIFY, That I attended deceased from March 10 - 1929, to March 23, 1929 that I last saw her alive on March 23, 1929, and that death occurred, on the date stated above, at 12:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

P3A
Pulmonary TB
Suberculosis
Person known (duration) yrs. 0 mos. 13 da.

CONTRIBUTORY (SECONDARY) 7 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

9 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

19. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical Symptom
 (Signed) J. W. Althoff M. D.
 , 19 (Address) 1014 1/2 Perser

*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 3-26-1929

20. UNDERTAKER Enter Funeral Home ADDRESS 4107 Finney

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

