

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

Do not use this space.

16697

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1002

City..... (No. 3000)

File No.

Registered No. 4814

St. Ward)

2. FULL NAME Mary Lewis

(a) Residence No. 3000 St. 19 Ward.

(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

col

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 24 - 1891

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>57</u>	<u>-</u>	<u>-</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House/keeper
 (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) St Louis mo

10. NAME OF FATHER John Gray

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St Louis mo

12. MAIDEN NAME OF MOTHER Chas Gray

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) St Louis mo

14. INFORMANT Ruth Payne
(Address) 3025 Ruyter

15. FILED 26 191920 M. C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-24-1929

17. I HEREBY CERTIFY, That I attended deceased from 4-18-, 1929, to 4-24-, 1929 that I last saw her alive on 4-23-, 1929, and that death occurred, on the date stated above, at 1:20 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral apoplexy
92 A
1:30

CONTRIBUTORY (SECONDARY)

acute Brights disease (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? Clinical symptoms
(Signed) J. T. Anderson M. D.

(Address) 3201A Lockeda

*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 4-29 1929

20. UNDERTAKER

Watson and Son ADDRESS 2941 Chouteau

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.

