

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

Do not use this space.

16745

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **103**
 City *St. Louis* (No. *City Hospital #2*) St. _____ Ward)

File No. _____
 Registered No. **4864**

2. FULL NAME

Clara Hamilton
 (a) Residence No. *8 S. 22d* St. *75* Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Col.* 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) *June 2, 1906*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
22 10 21

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. *Factory worker*
 (b) General nature of industry, business, or establishment in which employed (or employer). *Nut Factory*
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *La.*

10. NAME OF FATHER *Daddy Specie*

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

12. MAIDEN NAME OF MOTHER *Estella Campbell*

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

14. INFORMANT *Anna F. Woodard* (Address) *City Hospital #2*

15. FILED *APR 27 1929* REGISTRAR *Walter Richter*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-23-1929*

17. I HEREBY CERTIFY, That I attended deceased from *4-18-1929* to *4-23-1929* that I last saw him *22* alive on *4-23-1929* and that death occurred, on the date stated above, at *12:30 p. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Golden Pneumonia
 (duration) yrs. mos. *7* ds.

CONTRIBUTORY (SECONDARY) *101W* (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? *x rays*
 (Signed) *F. E. Cunningham*, M. D.
 , 19 (Address) *2945 Solvator*

*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 U.* DATE OF BURIAL *April 27 1929*

20. UNDERTAKER *Walter Richter* ADDRESS *3500 Rutger*

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.

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