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

Do not use this space.

23394

File No. 6881

Registered No.

1. PLACE OF DEATH

County

Township

City St Louis (No. City Hospital #2 St. Ward)

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME Hattie Dunlap

(a) Residence. No. 2729 Walnut St., 22 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Col.

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): Unknown

7. AGE: Years abt. 28 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Maid
(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): Ark.

PARENTS

10. NAME OF FATHER: Unknown

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

12. MAIDEN NAME OF MOTHER: Fannie Williams

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

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

15. FILED ..... 19.. Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 6-27- 1929

17. I HEREBY CERTIFY, That I attended deceased from 6-22-, 1929, to 6-27-, 1929 that I last saw her alive on 6-27-, 1929, and that death occurred, on the date stated above, at 9:30 pm. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebro Spinal Meningitis of Unknown Etiology

(duration) ....yrs. ....mos. 12 ds.

CONTRIBUTORY (SECONDARY)

(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF no

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A E Hale, M. D.

6/28/1929 (Address) City Hospital #2

*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: E St Louis Illinois

DATE OF BURIAL: 7-1-1929 19

20. UNDERTAKER: Wm E Officer

ADDRESS: E St Louis Ill

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.