

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

Do not use this space.

26409

**1. PLACE OF DEATH**

County St. Louis Registration District No. 791  
Township no. Primary Registration District No. 1003  
City City Hospital #2 (No. City Hospital #2)

File No. \_\_\_\_\_  
Registered No. 7645  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence No. 230 St. Christopher St. Ward 5

(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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-3-1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
29 3 6

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Okla.  
(STATE OR COUNTRY)

10. NAME OF FATHER Jack Jones

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

12. MAIDEN NAME OF MOTHER Anna

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

14. INFORMANT A. Gertrude Creath  
(Address) City Hospital #2

15. FILED JUL 21 1929 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-9 1929

17. I HEREBY CERTIFY, That I attended deceased from June 23 1929, to July 9 1929 that I last saw him alive on July 9 1929, and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Home

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? X-ray & Sputum

(Signed) H. W. Leathers, M. D.

710, 1929 (Address) City Hosp #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 DATE OF BURIAL

Washington Park Cem. 7/25 1929

20. UNDERTAKER ADDRESS

Peiskie Loney 3129 Lucas

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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