

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

Do not use this space.

26451

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis, Mo. (No. City) Sanitarium Ward

File No.....
 Registered No. 7710
 St. Ward

2. FULL NAME

Matilda Penn
 (a) Residence. No. 2705 Bernard St. 13 Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 30 yrs. 4 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 Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 26, 1868

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>61</u>	<u>4</u>	<u>22</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Bowling Green
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT Frank H. White
 (Address) 5300 Arsenal

15. FILED 11 25 1929 Ray E. Roney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/18/29 19

17. I HEREBY CERTIFY, That I attended deceased from 1/17/29, 19... to 7/18/29, 19... that I last saw h. alive on 7/17/29, 19... and that death occurred, on the date stated above, at 5:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Phylitis of the Central Nervous System

CONTRIBUTORY (SECONDARY) 3 1/2 (duration) yrs. 6 mos. 0 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 + Lab
 (Signed) Frank H. White, M. D.

7/18/29, 19 (Address) 5300 Arsenal

*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 July 25 19 29

20. UNDERTAKER ADDRESS 2620

J W Hughes Lawton

WRITE PAINLY, 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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