

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

Do not use this space.

26673

**1. PLACE OF DEATH**

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

File No.....  
 Registered No. **8027**  
 St..... Ward)

**2. FULL NAME**

**Lametta Perkins**  
 (a) Residence. No. **1516 Gratiot** St., **12** Ward.  
 (Usual place of abode)  
 Length of residence in city or town where death occurred: **Life** mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Female</b>	4. COLOR OR RACE <b>col.</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>Single</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Single</b>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <b>6-11-1921</b>		
7. AGE YEARS <b>8</b>	MONTHS <b>1</b>	DAYS <b>16</b>
If LESS than 1 day, ..... hrs. or ..... mts.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <b>Student</b> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

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

<b>PARENTS</b>	10. NAME OF FATHER <b>Ezekiel Perkins</b>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... <b>Miss.</b> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <b>Lucy Jones</b>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... <b>Miss.</b> (STATE OR COUNTRY)

14. INFORMANT **Robert L. Creath**  
 (Address) **City Hospital # 2**

15. **ADD - 1925**  
 FILED..... 19..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **7-27-1929**

17. I HEREBY CERTIFY, That I attended deceased from **6-28-29**, 19....., to **7-27-** 19....., and that I last saw her alive on **7-27-** 19....., and that death occurred, on the date stated above, at **6 P.M.** m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Chronic myocarditis**  
**930** (duration) ..... yrs. .... mos. .... ds.

CONTRIBUTOR (SECONDARY) **108** (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED.....  
 IF NOT AT PLACE OF BIRTH.....  
 DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....  
 WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **Clinical + X Ray**  
 (Signed) **A. E. Hale** M. D.  
**7/28/29** (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 **Washington Park** DATE OF BURIAL **8-3 1929**

20. UNDERTAKER **A. F. B. Baker, Walter** ADDRESS **2801 Stockland**

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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