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 St. ..... Ward)

File No. .....

Registered No. 8065

2. FULL NAME Bertha Epperson

(a) Residence. No. 3050 Thomas St., 21 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	col.	Wid.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-14-1875

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	54	—	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Domestic
(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) Mo.

PARENTS

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Marie Barnes

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

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

15. FILED AUG -5 1929 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-31- 1929

17. I HEREBY CERTIFY, That I attended deceased from 7-2-29, to 7-31-, 1929 that I last saw her alive on 7-31-, 1929 and that death occurred, on the date stated above, at 4 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

23A

Pulmonary Tuberculosis

(duration) ..... yrs. 6 mos. ..... 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 —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X-Ray & Sputum

(Signed) A E Hale M. D.

7/31/, 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 Greenwood

DATE OF BURIAL 8/3 1929

20. UNDERTAKER C. W. Roberts

ADDRESS 3030 Lucas

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.