

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

Do not use this space.

28972

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis (No. City Hospital)
6367 Elmer Clark St. Ward)

File No.....
Registered No. 8030
St. Ward)

2. FULL NAME

(a) Residence. No. 920 Taylor St., 26 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 6 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 White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 16 1923

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 10 28

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Chore girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY)

10. NAME OF FATHER Elmer Clark

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

12. MAIDEN NAME OF MOTHER Marg T. Fuller

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

14. INFORMANT Elmer Clark
(Address) City Hospital

15. FILED 19 May 2 Starkley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 5 1929

17. I HEREBY CERTIFY, That I attended deceased from July 27 1929 until I last saw him alive on Aug 5 1929 and that death occurred, on the date stated above, at City Hospital

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chorea
hemorrhage following
Tonsillectomy (duration) Operation ds.
CONTRIBUTORY (SECONDARY) for chronic tonsillitis
non epileptic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, DID AN OPERATION PRECEDE DEATH? DATE OF.....
WAS THERE AN AUTOPSY? 10/15/29

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. J. Woodward M. D.
1929 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or if 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 Atton Dec. DATE OF BURIAL Aug 7 1929

20. UNDERTAKER Robt. H. Streepor ADDRESS Atton Dec.

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.

MAINTAIN RECEIVED FOR DRIVING

V. 3000. Z.

Chart.