

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

Do not use this space.

35110

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

File No.....

Registered No.....

9833

City.....

(No.....)

St.....

Ward.....

2. FULL NAME

Willie Neal Glasgow

(a) Residence. No. *1722 Glasgow* St., *20* Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widow

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

James

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

Unknown

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

abt. 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Home work

(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)

Miss

10. NAME OF FATHER

Edie Clark

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

12. MAIDEN NAME OF MOTHER

Sarah Boyd

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

14.

INFORMANT (Address)

*Lillie Sampkins
1722 Glasgow*

15.

FILED..... 19.....

*Oct - 5 1927
Max C. Starkloff*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

10 - 2 - 1929

17.

I HEREBY CERTIFY That I attended deceased from *9-30-1928* to *10-2-1929* that I last saw him alive on *10-2-1928* and that death occurred, on the date stated above, at *7:30 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS

*Consumption
Pulm. Tuberculosis*

23A

Ray History

(duration) yrs. mos. *95* da.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

1722 Glasgow

DID AN OPERATION PRECEDE DEATH.....

No DATE OF.....

WAS THERE AN AUTOPSY.....

No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed).....

J. T. Edwards

M. D.

, 19.....

(Address) *149 Wagon St.*

*State the DISEASE CAUSING DEATH, or in death 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

Greenwood Cem.

Oct. 5 1929

20. UNDERTAKER

J. W. Hughes

ADDRESS

*267th
Kantaw*

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

