

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

Do not use this space.

39066

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(No. *6* south to City Hospital #2 St. Ward)

File No.....

Registered No.....

11546

2. FULL NAME

Sallie Washington

(a) Residence. No. *2324 R. Poplar* St., *22* 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. ds.

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Col

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

Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Not known*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

about 47

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) *St Louis*

(STATE OR COUNTRY)

10. NAME OF FATHER *Tom Washington*

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

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Lisa Williams*

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

(STATE OR COUNTRY)

14.

INFORMANT *Mr. Washington*

(Address) *2324 R. Poplar St*

15.

FILED *NOV 26 1929*

19.....

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov. 21* 19 *29*

17. No Physician in attendance. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... *7:43 A* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

792

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Ch. Sarcoidosis
Ch. Endocarditis (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? *yes*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *John R. ...* M.D.

11/22, 1929 (Address) *Deputy Coroner*

*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

Father Dickerson

Nov 27 19 29

20. UNDERTAKER

ADDRESS *2726*

A. J. Reed and Co.

Subson.

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.

PERMANENT RECORD

