

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

Do not use this space.

42458

1. PLACE OF DEATH

County.....
Township.....
City..... **St. Louis**

Registration District No. **791**
Primary Registration District No. **1003**
(No. **5915 Cates Ave.**)

File No. **12190**
Registered No. **12190**
St. _____ Ward _____

2. FULL NAME CARRIE E. BANGS

(a) Residence, No. **5915 Cates Ave.** St. **5** 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 **White** 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) **12/2/1853**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 0 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **None**
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Washington**
(STATE OR COUNTRY) **D.C.**

10. NAME OF FATHER **John W. Bangs**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Washington**
(STATE OR COUNTRY) **D.C.**

12. MAIDEN NAME OF MOTHER **Delphia Jenkins**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) **Maryland**

14. INFORMANT (Address) **5915 Cates Ave.**

15. FILED **DEC 15 1929** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec 14 1929**

17. I HEREBY CERTIFY, That I attended deceased from **September 21, 1929, to Dec 14, 1929** that I last saw him alive on **Dec 13, 1929**, and that death occurred, on the date stated above, at **9:20 A** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

cerebral hemorrhage
(duration) yrs. **6** mos. ds.

CONTRIBUTORY (SECONDARY) **Arteriosclerosis**
possibly years longer (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IS NOT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? **no** DATE OF _____
WAS THERE AN AUTOPSY? **no**
WHAT TEST CONFIRMED DIAGNOSIS? **physical findings**
(Signed) **W. H. Clithero** M. D.

12-14-1929 (Address) 906 Chelton Bldg

*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

Oak Grove Cem. 12/16/1929 19

20. UNDERTAKER **Alexander Dow** ADDRESS **6175 Delmar**

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.

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PARENTS

