

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

Do not use this space.

42631

1. PLACE OF DEATH

County.....

Registration District No. 791
1003

Township.....

Registration District No. 2

City St. Louis Mo.

City Hospital # 2

File No.
Registered No. 12412
St. (Ward)

2. FULL NAME

(a) Residence. No. 2628(A) Morgan 21 Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 14 yrs 1 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-16-1900

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
29 - 4 - 1

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

10. NAME OF FATHER John Motley

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

12. MAIDEN NAME OF MOTHER Sallie Monroe

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

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

15. FILED: DEC 21 1929 May C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/17/29 19

17. I HEREBY CERTIFY, That I attended deceased from 12-16-29, 1929, to 12-17-29, 1929, that I last saw her alive on 12-17-29, 1929, and that death occurred, on the date stated above, at 9:05 m.

108 THE CAUSE OF DEATH* WAS AS FOLLOWS: 9:05 pm

Lobar Pneumonia
(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (SECONDARY) 10:00
(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? Clinical

(Signed) A. G. Hale, M. D.

12/18/29 (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 Father Dicksons DATE OF BURIAL 12/22 1929

20. UNDERTAKER C. W. Roberts ADDRESS 3035 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.

WRITE IN FULL WITH UNFADING INK—THIS IS A PERMANENT RECORD

