

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

Do not use this space.

791
1003

2936

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City St Louis (No.....) 21 N 21 St

File No.....

Registered No. 384

St..... Ward.....

2. FULL NAME

(a) Residence No. 21 N 21 St St. 21 Ward.....

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Negro

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)

Sept 28 1929

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

3

15

8. OCCUPATION OF DECEASED

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

Child

(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)

St Louis Mo

10. NAME OF FATHER

George Avery

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

12. MAIDEN NAME OF MOTHER

Odesa Fowler

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

14.

INFORMANT

(Address)

George Avery
21 N 21 St

15.

FILED JAN 13 1930

M. C. Parke
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan 13 1930

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19....., and that I last saw him alive on 11/13/30 and that death occurred, on the date stated above, at 9038

11A THE CAUSE OF DEATH* WAS AS FOLLOWS:

108 Lepus Pneumonia

CONTRIBUTORY (SECONDARY)

Lo Guffa (duration) yrs. mos. ds. 6
3 (duration) yrs. mos. ds. 3

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

9 DID AN OPERATION PRECEDE DEATH DATE OF.....

WAS THERE AN AUTOPSY? no

WAS TEST CONFIRMED OF DIAGNOSIS?

(Signed) J. Jones, M. D.

11/12/30 (Address) 2603 Morgan

*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

Greenwood

1/14 1930

20. UNDERTAKER

ADDRESS

Russell Ind Co 2732 Pine

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.

