

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

Do not use ~~1934~~  
~~1935~~

3252

**1. PLACE OF DEATH**

County..... Registration District No.....  
Township..... Primary Registration District No.....  
City St. Louis, Mo. City Hospital # 2 St. 748 Ward

**2. FULL NAME**

Elizabeth Anthony  
(a) Residence. No. 1478 N. 21st St. Ward 21  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 4 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  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. abt. 15  
8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work nil  
(b) General nature of industry, business, or establishment in which employed (or employer) School  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas  
10. NAME OF FATHER Unknown  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
12. MAIDEN NAME OF MOTHER Unknown  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT d. Gertrude Clark  
(Address) City Hospital #2

15. FILED 23 1430 Wm C. Stanley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-17-1930  
17. I HEREBY CERTIFY, That I attended deceased from 1-1-1930 to 1-17-1930 that I last saw him alive on 1-17-1930 and that death occurred, on the date stated above, at 3:40 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pulmonary Tuberculosis  
2 1/2 yrs. (duration) 4 1/2 months

CONTRIBUTORY (SECONDARY) 3 1/2 (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) H.C. Hale, M. D.  
1/18/1930 (Address) City Hosp #2

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Washington Park. DATE OF BURIAL 1-23-1930

20. UNDERTAKER Atkins and Co. ADDRESS 3317 Morgan St.

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 PLAINLY, WITH OBTAINING THIS IS A LEGAL DOCUMENT

