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

Do not use this space. ~~3104~~ 3538 ~~2967~~

1. PLACE OF DEATH

County ..... Registration District No. 791 ..... File No. .....

Township St. Louis ..... Primary Registration District No. 1003 ..... Registered No. 1040

City St. Louis (No. 5600, Arsenal St. 24th Ward)

2. FULL NAME Pearl Smith

(a) Residence. No. 3208 1/2 Laclede St., 18 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Fem ~~Colored~~	Colored	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt. 33	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ~~Unknown~~
(b) General nature of industry, business, or establishment in which employed (or employer) Laundress
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.
(STATE OR COUNTY)

PARENTS

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

14. INFORMANT Dr. Koffler
(Address) ISOLATION HOSPITAL

15. FILED 1 31 1930 Ray C. Tarbox
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-30 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-25, 1930 to 1-30, 1930 that I last saw him alive on 1-30, 1930, and that death occurred, on the date stated above, at 2:45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis, Meningococcic
19
107A
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) Bronchopneumonia
(duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) [illegible] M. D.
1-30, 1930 (Address) ISOLATION HOSPITAL

*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	Feb 1st 1930
20. UNDERTAKER	**ADDRESS**
A. L. Beal and Co.	2726 Lucas Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.