

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

Do not use this space.

7290

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... **St. Louis Mo. City Hosp. #2**

File No.....
Registered No. **2184**
St. Ward)

2. FULL NAME

Wilma Thompson
(a) Residence. No. **1427 N 16th** St. **25** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **2** 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 OR DIVORCED** **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF **Dennis Thompson**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **9-14-1902**

7. AGE
YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
27 5 14

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

9. BIRTHPLACE (CITY OR TOWN) **Houston**
(STATE OR COUNTRY) **Texas**

10. NAME OF FATHER **M. C. Chapple**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Houston**
(STATE OR COUNTRY) **Texas**

12. MAIDEN NAME OF MOTHER **Ella Hammar**

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

14. INFORMANT **A. G. G. G. G. G.**
(Address) **City Hospital #2**

15. FILED **1930** **REGISTRAR**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2-28 1930**

17. I HEREBY CERTIFY, That I attended deceased from **2-10** 19**30** to **2-28** 19**30**
that I last saw h **e** alive on **2-28** 19**30**, and that death occurred, on the date stated above, at **6:25** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhage (uterine)
Child birth
CONTRIBUTORY (SECONDARY) **Child birth**

18. WHERE WAS DISEASE CONTRACTED **Home**
IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **H. H. H. H. H.** M. D.

(Address) **City Hosp #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 **Houston Texas** **DATE OF BURIAL** **3/7 1930**

20. UNDERTAKER **Peoples Und. Co.** **ADDRESS** **3100 Franklin**

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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