

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

Do not use this space.

10563

1. PLACE OF DEATH

County.....*St. Louis*..... Registration District No. *791*
 Township.....*St. Louis*..... Primary Registration District No. *1002*
 City.....*St. Louis*..... (No. *Peoples Hospital*)..... St. *St. Louis, Co.* Ward)

2. FULL NAME

Mariah Cropper
 (a) Residence. No. *9837 Laguna* St. *21* Ward. *St. Louis, Co.*
 (Usual place of abode) (If nonresident, give city or town and State)
 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 <i>Female</i>	4. COLOR OR RACE <i>Colored</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Divorced</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *abt. 1870*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>abt 60</i>		<i>Unknown</i>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Cook*
 (b) General nature of industry, business, or establishment in which employed (or employer). *Family Resident*
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....*Not Known*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Not Known*

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....*Not Known*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Not Known*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....*Not Known*
 (STATE OR COUNTRY)

14. INFORMANT *Mrs. H. D. Harris*
 (Address) *Hoda Freeman Ave*

15. FILED *Key C. Starks* 19 *31*

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 10 1930*

17. I HEREBY CERTIFY, That I attended deceased from *3-6-30* to *3-10-30*, 19*30*, that I last saw h. *9* alive on *3-10*, 19*30*, and that death occurred, on the date stated above, at *1:30 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia
92A
107A
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *100A*
Malaria (duration) yrs. *3* mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *J. H. Hill* M. D.
3/17/30 (Address) *7700 Locust Ave*

*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 <i>Washington Park</i>	DATE OF BURIAL <i>3/17 1930</i>
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20. UNDERTAKER <i>Wassell Mfg. Co.</i>	ADDRESS <i>4054 Freeman</i>
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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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