

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

Do not use this space.

11233

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis*

Registration District No. *791*
Primary Registration District No. *ISOLATION HOSPITAL*

File No.....
Registered No. *3240*
St. *24th* Ward)

2. FULL NAME

(a) Residence. No. *2232 Morgan St.* *21* Ward.

(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>married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Albert Caldwell</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>8-5/1910</i>		
7. AGE	YEARS <i>19</i>	MONTHS <i>7</i>
	DAY <i>14</i>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <i>Housework</i> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) *Arkansas*
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <i>Noah Lutter</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <i>Arkansas</i> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <i>Mattie McClellan</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <i>Miss</i> (STATE OR COUNTRY)

14. INFORMANT *C. Sheridan*
(Address) *ISOLATION HOSPITAL*

15. FILED *1930* REGISTRAR *Miss C. Starnes*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-29* 19 *30*

17. I HEREBY CERTIFY, That I attended deceased from *3-18*, 19 *30*, to *3-29*, 19 *30*, that I last saw h. *h.* alive on *3-29*, 19 *30*, and that death occurred, on the date stated above, at *10:10 A.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis Meningococci

18. WHERE WAS DISEASE CONTRACTED
18 (duration) yrs. mos. *5* ds.

CONTRIBUTORY (SECONDARY) *24* (duration) yrs. mos. ds.

19. DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *Albert Caldwell*, M. D.
3-29-1930 (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 <i>Creswood Cemetery</i>	DATE OF BURIAL <i>4/2/1930</i>
20. UNDERTAKER <i>R. C. Houston, Jr.</i>	ADDRESS <i>2812 Thomas</i>

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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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