

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

Do not use this space.

14783

**1. PLACE OF DEATH**

County.....  
Township *St Louis Mo.*  
City *St Louis Mo.* (No. *City Hospital 2*)

Registration District No. *791*  
Primary Registration District No. *100*

File No. ....  
Registered No. *4193*  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. *2721 Sheridan St.*, *21* Ward.

(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 *Female* 4. COLOR OR RACE *Col* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widow*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *2-17-1877*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*53 2 4*

**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)  
(c) Name of employer

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

10. NAME OF FATHER *Ben Thomas*

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

12. MAIDEN NAME OF MOTHER *Mary Graham*

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

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

15. FILED *APR 26 1930* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-21 1930*

17. I HEREBY CERTIFY, That I attended deceased from *4-13* 19*30*, to *4-21* 19*30*, and that I last saw him alive on *4-21* 19*30*, and that death occurred, on the date stated above, at *7:45* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*58 Gout (Bone)*

(duration) *13* yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *52 B*  
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY?

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

*4/22 1930* (Address) *City Hoop #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 *E. St Louis, Mo.* DATE OF BURIAL *4/27 1930*

20. UNDERTAKER *R. M. C. Green* ADDRESS *3517 Acade*

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 UNFADING INK—THIS IS A PERMANENT RECORD

2

200

