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.

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

Do not use this space.

14798

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 4208

City St. Louis (No. 6116 Minnesota St. ..... Ward)

2. FULL NAME Mica Craig

(a) Residence. No. 6116 Minnesota St., 1 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)
Female	Negro	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unk 1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
Abt	62	Unknown		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) " (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER "

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

14. INFORMANT Fredrick Givens (Address) 612 S. Garrison

15. FILED APR 25 1930, 19 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 21. 1930

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to April 21, 1930, that I last saw her alive on April 21, 1930, and that death occurred, on the date stated above, at 8 30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
34
92A

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY) Endarteritis (Luetic)

..... (duration) 3 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH "

DID AN OPERATION PRECEDE DEATH? no DATE OF "

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Kahn Test (Physical Signs)

(Signed) Fred S. Perrington M. D.

, 19 (Address) 1122 Wilmington

*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 Cem.	4-27-1930

20. UNDERTAKER	ADDRESS
Gates Funeral Home	4107 Finney Ave.