

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

Do not use this space.

14860

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1008  
 City St. Louis New City Hosp #2

File No.....  
 Registered No. 4276  
 St..... Ward)

**2. FULL NAME**

Carrie Clark  
 (a) Residence No. 122 A. Seward St., 23 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) 1-26-1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
33 2 29

**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) Worker  
 (c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Miss

10. NAME OF FATHER Sidney Johnson

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

12. MAIDEN NAME OF MOTHER Winnie Clark

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

14. INFORMANT A Gertrude Creath  
 (Address) City Hosp #2

15. FILED PH 24 1930 Wm C Stanley REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-25 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-7, 1930, to 4-25, 1930, that I last saw her alive on 4-25, 1930, and that death occurred, on the date stated above, at 11:15 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Gen. Peritonitis  
120R  
129 (duration) yrs. mos. ds.  
 CONTRIBUTORY Reptured Ulcer  
 (SECONDARY) Stem (Type) Ulcer not determined  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home  
 IF NOT AT PLACE OF DEATH  
 DID AN OPERATION PRECEDE DEATH? yes DATE OF 4-10-30  
 WAS THERE AN AUTOPSY? yes } mysterious  
 WHAT TEST CONFIRMED DIAGNOSIS? Autopsy  
 (Signed) H. H. Weathers, M. D.

4-28 19 30 (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 DATE OF BURIAL  
Winter City Miss Apr 30 1930

20. UMBERTAKER ADDRESS 3317  
H. J. Atkins Morgan  
St

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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