

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.

18243

1. PLACE OF DEATH

County.....

Registration District No.

Township.....

Primary Registration District No.

City *St. Louis* (No. *2820*)*Mill*

File No.

Registered No.

5764

St.

Ward)

2. FULL NAME

(a) Residence. No. *2820 Mill*

St.

21

Ward.

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)

Married

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

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

abt. 1888

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ... hrs. or min.

abt 42 unknown unknown

8. OCCUPATION OF DECEASED

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

Domestic

(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)

Mo.

10. NAME OF FATHER

John Blake

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

14.

INFORMANT.
(Address)*Fred Smith
2926 Broadway ave*

15.

FILED

1930 May 14

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

May 29 1930

17.

I HEREBY CERTIFY, That I attended deceased from *May 29* 1930, to *May 29* 1930, that I last saw *her* alive on *May 29* 1930, and that death occurred, on the date stated above, at *2 a.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

Bronchial Pneumonia

CONTRIBUTORY (SECONDARY)

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?

(Signed) *W. C. ...*

M. D.

, 19

(Address) *2746 ...*

*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

*Guthrie Dickson**June 14 1930*

20. UNDERTAKER

A. S. Walton

ADDRESS

2701 Stoddard

