

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

Do not use this space.

21088

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **905^a S. 14th St.**)

File No. **5939.**
Registered No. **5939.**
St. Ward)

2. FULL NAME **Jabrina Wessells.**

(a) Residence No. **905 S. 14th St.** St. **25** 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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
abt 66		✓	✓	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. **at home.**
(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) **Unknown**

10. NAME OF FATHER
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 **J. W. Kerney**
(Address) **Coroner's Office**

15. FILED **19 1939** **May 11 1939**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6/16/30** 19

17. **No Physician attended**
I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at **3:40 P.** m.

164c THE CAUSE OF DEATH* WAS AS FOLLOWS:
Asphyxiation (Due to food go poisoning) self administered
(duration) yrs. mos. ds.
CONTRIBUTORY **Suicide**
(duration) yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....
WAS THERE AN AUTOPSY? **No.**

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **J. W. Kerney, M.D.**
6/19/30 (Address) **Dep Coroner**

*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 **St. Lawrence Cemetery** DATE OF BURIAL **6/19 1930**

20. UNDERTAKER **Ziegenhagen Bros.** ADDRESS **2621 Cherokee**

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.

