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

Do not use this space.

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File No. .....
Registered No. 6909

1. PLACE OF DEATH

County .....
Township .....
City St. Louis No. Barnsdale City Hosp # 2 St. ..... Ward)

Registration District No. .....
Primary Registration District No. .....

2. FULL NAME Alice Lewis

(a) Residence. No. 19 Johnson 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 26 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: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-25-1867

7. AGE: Years 62 | Months 6 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) New Orleans
(STATE OR COUNTRY) La

PARENTS

10. NAME OF FATHER Charles Landers
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) La.
12. MAIDEN NAME OF MOTHER Rose Moore
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) La.

14. INFORMANT Patterson Lewis
(Address) 19 Johnson St.

15. FILED JUL 14 1930 Mary C. Hoffman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-2 1930

17. 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 1:25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1(a) Heart Prostration

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

CONTRIBUTORY (SECONDARY) .....

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

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

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) John Murray M.D.
7/14, 1931 (Address) Deputy 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: Washington Park — DATE OF BURIAL: July 17 1930

20. UNDERTAKER: William Offers — ADDRESS: St. Louis

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.