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.

24985

791

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. ..... Registered No. 7154

City St Louis, Mo (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Baby Beasley

(a) Residence. No. 14 39 No - 16 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. 6 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	Col.	—

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-7-1930

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
—	—	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Wesley Beasley

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

12. MAIDEN NAME OF MOTHER Wennie Henry

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

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

15. FILED JUL 18 1930 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-13-1930

17. I HEREBY CERTIFY, That I attended deceased from 7-7-, 1930, to 7-13-, 1930 that I last saw her alive on 7-7-, 1930, and that death occurred, on the date stated above, at 12:10 P m.

34 THE CAUSE OF DEATH* WAS AS FOLLOWS:
150

Malnutrition (duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (SECONDARY) Lues

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH unknown
DID AN OPERATION PRECEDE DEATH? NO. DATE OF —
WAS THERE AN AUTOPSY? NO
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Lab

(Signed) H. C. Hampton, M. D.

7-15-1930 (Address) City Hospital #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
POTTERS FIELD	7-24-1930
20. UNDERTAKER	ADDRESS
Roy Alston 2945 Lawton	