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

Do not use this space.

25298

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

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

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

File No. .....

Registered No. 7530.

2. FULL NAME Anna Patterson

(a) Residence. No. 1720 Morgan St., 25 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. 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	Divorced

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt. 2	3	—	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-Maid

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

PARENTS

10. NAME OF FATHER Henry Barker

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

12. MAIDEN NAME OF MOTHER unknown

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

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

15. FILED JUL 28 1930 19 Max C Starkley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-23- 1930

17. I HEREBY CERTIFY, That I attended deceased from 7-16-, 1930, to 7-23-, 1930 that I last saw her alive on 7-23-, 1930, and that death occurred, on the date stated above, at 10:15 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23H (duration) yrs. 9 mos. ds.

CONTRIBUTORY (SECONDARY) unknown

(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) Henry E Hampton M. D.

7-24-1930 (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 E. St Louis Ill

DATE OF BURIAL 7-28 1930

20. UNDERTAKER R. M. Green

ADDRESS E. 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.