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

Do not use this space.

25338

791
1003

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. ..... Registered No. 7571

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

2. FULL NAME (Mittie) Smith of Mittie

(a) Residence (Usual place of abode) No. 1014a N. 11th St., 25 Ward. ..... (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	Col	widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-1-1877

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	53	3	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Miss

PARENTS

10. NAME OF FATHER Bob White

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

12. MAIDEN NAME OF MOTHER Sylvia White

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

14. INFORMANT a Gertrude Creath (Address) City Hosp #2

15. FILED JUL 29 1930, 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-18 1930

17. I HEREBY CERTIFY, That I attended deceased from 7-10, 1930, to 7-18, 1930 that I last saw her alive on 7-18, 1930, and that death occurred, on the date stated above, at 4:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Myocarditis

936
97
102 (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (SECONDARY) arterio Sclerosis hypertension (duration) ..... yrs. 4 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 - X Ray Lab

(Signed) Henry E Hampton M. D.

7-19, 1930 (Address) City Hosp #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
Mather Dickson	7-30 1930
20. UNDERTAKER	ADDRESS
Gates Funeral Home	4101 Finney

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.