

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis (No. 11037)

File No. 28182

Registered No. 8023

St. _____

Ward) _____

2. FULL NAME Aida Pugh

(a) Residence. No. _____

St. 21

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

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female Negro

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

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

12-15-1889

7. AGE

YEARS

MONTHS

DAYS

If LESS than day, _____ hrs. or _____ min.

40

7

21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Housework

(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)

Mississippi

10. NAME OF FATHER

Dennis Warren

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mississippi

12. MAIDEN NAME OF MOTHER

Jennie Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mississippi

14.

INFORMANT

(Address)

Minnie Harrison
2908 Franklin

15.

FILED

AUG 11 1930

Max C. Standiford

REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR)

8-6-1930

17.

I HEREBY CERTIFY, That I attended deceased from Nov-10-1929 to 8-6-1930 that I last saw her alive on 8-3-30, 1930 and that death occurred, on the date stated above, at 8 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial
Nephritis

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

CONTRIBUTORY (SECONDARY)

Don't know

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

18. WHERE WAS DISEASE CONTRAICTED

IF NOT AT PLACE OF DEATH

St. Louis, Mo

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) D. W. Brown

M. D.

8-11-1930 (Address) 822 1/2 N. Jefferson

*State the DISEASE CAUSING DEATH, or in death 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

Notchickickson

8-11-1930

20. UNDERTAKER

ADDRESS

Estes Funeral Home
4401

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.

