

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

Do not use this space.

28549

File No. _____
Registered No. **8454**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. 701
Township _____ Primary Registration District No. 100
City St. Louis, Mo. (No. City Hospital #2)

2. FULL NAME

Mabel M. Daniel
(a) Residence. No. 1443 N-18th 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 4 yrs. 2 mos. 0 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-26-1919

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>11</u>	<u>5</u>	<u>15</u>	

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) School
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Arkansas

10. NAME OF FATHER Eugene M. Daniel

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

12. MAIDEN NAME OF MOTHER Pearl Taylor

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

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

15. FILED AUG 26 1930 Max C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-11-1930

17. I HEREBY CERTIFY, That I attended deceased from 6-30-1930, 1930, to 8-11-1930, 1930 that I last saw him alive on 8-11-1930, 1930, and that death occurred, on the date stated above, at 10:25 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
0217
(duration) _____ yrs. 6 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? Original x-Ray-106
(Signed) Henry C. Hampton, M. D.
8-12-1930 (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 8/26/1930
Father Dierson

20. UNDERTAKER Wm. End Co ADDRESS 3317 Morgan St

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.

