

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

Do not use this space.
28579

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis, Mo.** (No. **City Hospital #2**)

File No.
Registered No. **8484**
St. Ward)

2. FULL NAME

Susan Ho Howay
(a) Residence No. **2715 Washington St.** 21 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred **70** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Colored** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

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.
About 70	-	-	-	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **Seamstress**
(b) General nature of industry, business, or establishment in which employed (or employer) **At Home**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

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

15. FILED **AUG 27 1930**
M. C. Stanley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **8-25-1930**

17. I HEREBY CERTIFY, That I attended deceased from **8-20-1930**, 1930, to **8-23-1930**, 1930, that I last saw h. e. f. alive on **8-23-1930**, and that death occurred, on the date stated above, at **9:45 a. m.**

131 228 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy

(duration) yrs. mos. ds. **3**

CONTRIBUTORY (SECONDARY) **Chr. nephritis**
(duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **Unknown**
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? **NO** DATE OF -

WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **Henry C. Sampson, M. D.**

8-25-1930 (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 **Greenwood** DATE OF BURIAL **8/27 1930**

20. UNDERTAKER **C. H. Roberts** ADDRESS **3035 Lucas**

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.

