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

Do not use this space.

File No. 31533

Registered No. 9146

1. PLACE OF DEATH

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

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

City St Louis (No. City Hospital ..... St. ..... Ward)

2. FULL NAME Arcella Burnett

(a) Residence. No. 1451 Warren St., 26 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 5 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	White	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-28-1911

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
19	7	23	

8. OCCUPATION OF DEASCED
(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) Missouri

PARENTS

10. NAME OF FATHER Lynn White

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

12. MAIDEN NAME OF MOTHER Lesha Kump.

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

14. INFORMANT Mrs. [illegible]
(Address) City Hospital

15. Sep 23 1930
FILED ....., 19 .....
Mary C. Stehly
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21 1930.

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Sept 21, 1930 that I last saw h. alive on Sept 21, 1930 and that death occurred, on the date stated above, at 6:18 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Syphilis

34 38 (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) .....

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

18. WHERE WAS DISEASE CONTRACTED .....

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical laboratory

(Signed) V. E. Scherman M.D.

9/22/30 (Address) City Hospital

*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 St Mathews Cemetery — DATE OF BURIAL 9-23 1930

20. UNDERTAKER McLaughlin — ADDRESS 1631 Mo ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. Information should be stated EXACTLY.

Turnell