

**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

34491

Township.....

Primary Registration District No.....

1003

File No.....

9867

City.....

(No.)

City Hospital #2

Registered No.....

St.....

Ward.....

2. FULL NAME

(a) Residence. No.

(Usual place of abode)

Sallie Hill

14th 900 Poplar St.

W. Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 12 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

ysr.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

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

Female

Col.

Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-17-1870

7. AGE

YEARS 60

MONTHS 6

DAYS 24

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

House wife

(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

10. NAME OF FATHER

Ben. Robinson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

12. MAIDEN NAME OF MOTHER

Harriet Amos

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-11-1930

17.

I HEREBY CERTIFY, That I attended deceased from 9-18-1930, to 10-11-1930, that I last saw h. e. p. alive on 10-11-1930, and that death occurred, on the date stated above, at 10:35 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. Myocarditis
1 yr.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Ch. Nephritis

(duration) 2 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

City Hospital - Lab.

(Signed)

Henry C. Hampton, M. D.

10-13-1930 (Address)

City Hosp. #2

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Father Dickson's Cem

10/19/1930

20. UNDERTAKER

ADDRESS

C. W. Roberts

3035 Lucas Ave

Exact statement of OCCUPATION is very important.

PARENTS

14. INFORMANT (Address)

A. Gertrude Creath
City Hospital #2

15. FILED 19

16
maub Starkey
REGISTRAR

