

**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..... St. Louis Mo Primary Registration District No. 1063  
 City..... St. Louis Mo (No. ISOLATION HOSPITAL St. \_\_\_\_\_ Ward \_\_\_\_\_)

**34494**

File No. \_\_\_\_\_  
 Registered No. 9870

**2. FULL NAME**

Cora Mae Payland  
 (a) Residence. No. 3160 School St. 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 8 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE Colored 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) unk

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
- abt 9 ? \_\_\_\_\_

**8. OCCUPATION OF DECEASED**

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

**PARENTS**  
 10. NAME OF FATHER ?  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_  
 12. MAIDEN NAME OF MOTHER Marietta unk  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) unk

14. INFORMANT ISOLATION HOSPITAL (Address) for Laffer

15. FILED May 6 1930 Starkoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 13 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930 to Oct 13, 1930 that I last saw her alive on Oct 12, 1930, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Malnutrition  
(Diphtheria carrier)  
10 d.  
 (duration) \_\_\_\_\_ yrs. ? mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY Bronchopneumonia  
 (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED ISOLATION HOSPITAL  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_ (Signed) Blattberg M. D.

10-13-1930 (Address) ISOLATION 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 POTTERS FIELD DATE OF BURIAL 10-13-1930

20. UNDERTAKER John Pausch 5800 Arsenal ADDRESS \_\_\_\_\_

