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

Do not use this space.

35012

791

1003

File No. .....

Registered No. 10770

1. PLACE OF DEATH

County .....

Township .....

City St Louis (No. City Hospital #2 St. ..... Ward)

Registration District No. .....

Primary Registration District No. .....

2. FULL NAME Willie Mae Wohald

(a) Residence. No. 710 N Jefferson 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 ..... yrs. ..... mos. ..... 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): Married Separated

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE: About 22 YEARS | MONTHS — | DAYS — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

(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 Anthony Jackson

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

12. MAIDEN NAME OF MOTHER Not Known

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

14. INFORMANT Abe Styles (Address) 4368 W Bell

15. FILED ..... 19.. Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-31-30

17. I HEREBY CERTIFY, That I attended deceased from ..... (No Physician in attendance) ....., 19....., to ....., 19....., that I last saw h..... alive on 15 19....., and that death occurred, on the date stated above, at 10 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Stab wound of back & chest (Knife)

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

CONTRIBUTORY (SECONDARY) Homicide

..... (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? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Wm V Dever M.D.

11/4, 1930 (Address) Coroner

*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: Natchez Miss

DATE OF BURIAL: 11-17-1930

20. UNDERTAKER: L R Wade Und Co.

ADDRESS: 4202 Finney Ave.

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.