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

41502

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 12190

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

2. FULL NAME Fila Lee

(a) Residence. No. 2747 Walnut St., 22 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: fe Male
4. COLOR OR RACE: Col.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

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

7. AGE: abh 30 Years | Months: — | Days: — | 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.

PARENTS

10. NAME OF FATHER: Will Anderson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Miss
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Miss

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

15. FILED: DEC 30 1930 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12-21-1930

17. I HEREBY CERTIFY, That I attended deceased from 12-13-1930, to 12-21-1930, that I last saw her alive on 12-21-1930, and that death occurred, on the date stated above, at 3 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Myocarditis
131
936 (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Chr. Nephritis
(duration) 3 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? Clinical & Lab.

(Signed) Henry E. Hampton M. D
12-23, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Washington U. | DATE OF BURIAL: 12-27 1930

20. UNDERTAKER: Walter Richter | ADDRESS: 3500 D

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.

S. No. 2.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

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

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

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

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of 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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(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?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M. D
, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

V. S. No. 2.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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