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

Do not use this space.

7260

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 1570

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

2. FULL NAME Lillie Northcross

(a) Residence. No. 1405 N. 8th St. St., 25 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. 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	Col	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-21-1905

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	25	6	13	

8. OCCUPATION OF DECEASED
(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) Ark

PARENTS

10. NAME OF FATHER Jeff Gunthop

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT A. Gertrude Heath
(Address) City Hosp #2

15. FILED FEB -7 1931 Max C. Fowler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 4, 1931.

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1931, to Feb. 4, 1931, that I last saw her alive on Feb. 4, 1931, and that death occurred, on the date stated above, at 7:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

583
1298
1118 Acute Cardiac Dilatation
Pulmonary Embolism
..... (duration) 1 hour yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Uterus Fibroid
(Benign) (duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? Yes DATE OF Jan. 28, 1931. (Hysterectomy)
WAS THERE AN AUTOPSY? None
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms

1540

(Signed) H. H. Weathers, M. D.
2/5, 1931 (Address) City Hosp. No. 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Father Dickson	2-9-1931
20. UNDERTAKER	ADDRESS 4202
J. D. Vade	Finney

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.

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