

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

Do not use this space.

7639

1. PLACE OF DEATH

County.....

Registration District No. V1791

Township.....

Primary Registration District No. 510083

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

File No.
Registered No. 2000
St. Ward)

2. FULL NAME

(a) Residence. No. 609 HAMILTON St. 5 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 <u>F</u>	4. COLOR OR RACE <u>C</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>SINGLE</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>abt. 34</u>	<u>—</u>	<u>—</u>	<u>—</u>	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer). DOMESTIC SERVANT.

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo.
(STATE OR COUNTRY) 1

10. NAME OF FATHER Roy. PRINCE

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

12. MAIDEN NAME OF MOTHER DELLA THOMPSON

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

14. INFORMANT A. GERTRUDE CREATH
(Address) CITY HOSPITAL #2

15. FILED 14 1931 THOMAS C. STANLEY
19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-12-1931

17. I HEREBY CERTIFY, That I attended deceased from 2-8-1931 to 2-12-1931 that I last saw her alive on 2-12-1931, and that death occurred, on the date stated above, at 3:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CHR. PNEUMATIC PERICARDITIS

(duration) 3 yrs. 3 mos. — ds.

CONTRIBUTORY (SECONDARY) CHR. NEPHRITIS

(duration) 6 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH AT HOME

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? YES

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy - CLINIC - X-RAY

(Signed) Henry W. Johnston, M. D.

2-13-1931 (Address) City Hospital #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 <u>Woburn Park</u>	DATE OF BURIAL <u>2/15 1931</u>
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20. UNDERTAKER <u>Richardson & Tjker</u>	ADDRESS <u>1020 Brooklyn</u>
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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.

