

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

Do not use this space.

7783

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township St Louis Primary Registration District No. 1003  
 City St Louis (No. City Hospital # 2)..... St. .... Ward)

File No. ....  
 Registered No. 2150

**2. FULL NAME**

(a) Residence. No. 8933 Caban Place..... 5 Ward.  
 (Usual place of abode)  
 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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 30 1894

7. AGE	YEARS	MONTHS	DAY	IF LESS THAN 1 day, ..... hrs. or ..... min.
<u>34</u>	<u>5</u>	<u>13</u>		

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Butler 2411  
 (b) General nature of industry, business, or establishment in which employed (or employer). Private Family  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)..... Miss  
 (STATE OR COUNTRY) ?

10. NAME OF FATHER Not known

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

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... Not known  
 (STATE OR COUNTRY)

14. INFORMANT Mathie Holden  
 (Address) 2513 Innes Ave

15. FILED 17 19 31 May C. J. Stanley  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 13, 1931  
 17. No Physician or Attendance  
 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 1:25 P. m.

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

Anemia  
710  
1035  
 (duration) yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) None bleed- cause  
unknown (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) W. H. Newberry M. D.

216, 19 31 (Address) Dept. Cooper

\*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 Feb 17 1931

20. UNDERTAKER Marion Galt Co  
 ADDRESS 1234

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.

