

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

Do not use this space.

16556

1. PLACE OF DEATH

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

File No.
 Registered No. **5079**

2. FULL NAME

(a) Residence. No. *321 N. 20th* 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 *13* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>		4. COLOR OR RACE <i>Col</i>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Sep.</i>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>4-19-1894</i>					
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.	
	<i>37</i>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <i>Housework</i>					
(b) General nature of industry, business, or establishment in which employed (or employer) <i>222</i>					
(c) Name of employer					
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ala</i>					
PARENTS	10. NAME OF FATHER <i>Geo Hook</i>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Uniontown Pa</i>				
	12. MAIDEN NAME OF MOTHER <i>Luella Edwards</i>				
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Unknown</i>					

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-19* 19 *31*
 17. I HEREBY CERTIFY, That I attended deceased from *4-17* 19 *31* to *4-19* 19 *31* that I last saw him alive on *4-19* 19 *31*, and that death occurred, on the date stated above, at *B.R.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Miliary Tuberculosis
32A (duration) yrs. *2* mos. ds.
 CONTRIBUTORY (SECONDARY) *32W* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. *Home*
 DID AN OPERATION PRECEDE DEATH? *No* DATE OF
 WAS THERE AN AUTOPSY? *Yes*
 WHAT TEST CONFIRMED DIAGNOSIS *Spec. Autopsy*
 (Signed) *Henry E. Hampton*, M. D.
421, 19 *31* (Address) *City Hoop #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.

14. INFORMANT (Address) <i>A Gertrude Creeth</i> <i>City Hoop #2</i>	19. PLACE OF BURIAL, CREMATION, OR REMOVAL <i>Greenwood Cem.</i>	DATE OF BURIAL <i>4/29 19 31</i>
15. FILED <i>29</i> 19 <i>31</i> <i>Max C. Meloy</i> REGISTRAR	20. UNDERTAKER <i>C. W. Roberts</i>	ADDRESS <i>3035 Linn</i>

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.

