

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. 1791

Township.....

Primary Registration District No. 1003

City St. Louis MO (No. ISOLATION HOSPITAL)

19488
File No.
Registered No. 5441
St. Ward)

2. FULL NAME Vernice Oldham

(a) Residence. No. 114 Rankin St., 18 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 Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 5 1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
21 5 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife 235
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Ark.
(STATE OR COUNTRY)

10. NAME OF FATHER Ike Lane

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

12. MAIDEN NAME OF MOTHER Izula

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

14. INFORMANT Lamine Kroner
(Address) ISOLATION HOSPITAL

15. FILED MAY - 9 1931
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5 - 6 1931

17. I HEREBY CERTIFY, That I attended deceased from 4 - 25, 1931, to 5 - 6, 1931 that I last saw h. ex alive on 5 - 6, 1931, and that death occurred, on the date stated above, at 6:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis -
18 Meningococci
97N (duration) yrs. mos. 12 ds.
CONTRIBUTORY Meningeal - RT
(SECONDARY) (duration) yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? No (DATE OF.....)

18 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Culture of Lab

(Signed) L. F. Kompan, M. D.

, 19 (Address) ISOLATION HOSPITAL

*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 Washington RT DATE OF BURIAL 5/11/1931

20. UNDERTAKER Peoples Ind. Co ADDRESS Franklin

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.

1987
10/10/87