

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

Do not use this space.

19881

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**
(No. *City Hosp # 2*)

File No.....
Registered No. **5906**
St..... Ward.....

2. FULL NAME

(a) Residence, No. *2110 So 16th* St. *22* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *10* 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 *Col* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the ward) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Robert Watkins*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *5-4-1900*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
31 - - 16

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Hotel - Cook*
(b) General nature of industry, business, or establishment in which employed (or employer) *maid 244*
(c) Name of employer

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

10. NAME OF FATHER *Walter Bridewell*

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

12. MAIDEN NAME OF MOTHER *Alice Paul*

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

14. INFORMANT (Address) *A. Bernude Creath City Hosp # 2*

15. FILED *MAY 29 1931* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-20* 19*31*

17. I HEREBY CERTIFY, That I attended deceased from *5/14*, 19*31* to *5/20*, 19*31* that I last saw her alive on *5/20*, 19*31*, and that death occurred, on the date stated above, at *4:53 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

23A
Pulmonary Tuberculosis
(duration) yrs. *5* mos. ds.

CONTRIBUTORY (SECONDARY) *3*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *None*
ABOUT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....
WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *Clinical Lab - V-City*
(Signed) *B. B. Keathus*, M. D.

5/21, 1931 (Address) *City # 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
Helena Arkansas *5/19 1931*

20. UNDERTAKER ADDRESS
Peoples Und. Co. Franklin

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.

