

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

Do not use this space.

19924

1. PLACE OF DEATH

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

Registration District No. 781
Primary Registration District No. 1003

File No.....
Registered No. 5951
St..... Ward)

2. FULL NAME

Elaine Staple

(No. ISOLATION HOSPITAL)

(a) Residence. No. 2614 1/2 Stoddard 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 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-22-27

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>4</u>	<u>3</u>	<u>1</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Curry Staple

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

12. MAIDEN NAME OF MOTHER Elizabeth Gardner

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

14. INFORMANT Joe Laffler
(Address) ISOLATION HOSPITAL

15. FILED 21 1931 REGISTRAR ATI Talton

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-23 1931

17. I HEREBY CERTIFY, That I attended deceased from 5-22, 1931 to 5-23, 1931, that I last saw h. l. m. alive on 5-23, 1931, and that death occurred, on the date stated above, at 4:00 p.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

8 Scarlet Fever (duration) yrs. mos. 4 ds.
10 Diphtheria faucial (SECONDARY) (duration) yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Lab.
(Signed) L. F. Kompere, M. D.
ISOLATION HOSPITAL (Address)

*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 Greenwood DATE OF BURIAL 5/26/ 1931

20. UNDERTAKER ATI Talton ADDRESS 2701 Stoddard St

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.

