

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

Do not use this space.

20096

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City *St Louis Mo* (No. *City Hosp #2*)

File No.....
Registered No. **6120**
St. Ward)

2. FULL NAME

Lizzie Harrison
(a) Residence, No. *2231^{1/2} St Charles* Ward. *11*
(Usual place of abode)

(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 word)

Married

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

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

Unknown

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

abt 53

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

work 2-3

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

PARENTS

10. NAME OF FATHER

Jack Brooks

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

12. MAIDEN NAME OF MOTHER

Lizzie Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss

14. INFORMANT

(Address)

*A. Putzende Creath
City Hosp #2*

15. FILED

19

W. C. Harlow
REGISTRAR

781
1088

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-29* 19 *31*

17. I HEREBY CERTIFY That I attended deceased from *5-18* 19 *31* to *5-29* 19 *31*
that I last saw h. alive on *5-29* 19 *31*, and that death occurred, on the date stated above, at *12:45* a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131

Chromo nephritis

(duration) *2* yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Unknown

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

Home

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

20. WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Nancy E. Hompton* M. D.

St. Louis . 19 *31* (Address) *City Hosp #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

Foster Parkson

6-1-1931

20. UNDERTAKER

ADDRESS

W. S. Ward & Sons

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.

