

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

Do not use this space.

30150

1. PLACE OF DEATH

County.....

Registration District No. **91**

Township.....

Primary Registration District No. **008**

City **St. Louis** (No. **City Hospital #2**)

File No.

Registered No. **9375**

St.

Ward)

2. FULL NAME

Mary Clayton

(a) Residence. No. **3115** **Branden St.** **21** Ward. (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

Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Chester Clayton

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

Unknown

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

Abt.

35

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8. OCCUPATION OF DECEASED

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

Housewife

(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)

Arkansas

10. NAME OF FATHER

Jack Washington

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Arkansas

12. MAIDEN NAME OF MOTHER

Frances Holmes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Arkansas

14.

INFORMANT (Address)

**Chester Clayton
3115 Branden St.**

15.

FILED

SEP - 19 1931

Max C. Stanley

REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **8 - 21 1931**

17. No Physician in attendance
I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19....., and that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at..... **9:25 P.**.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Endocarditis

97A

107A

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Bronchial Pneumonia**

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

18 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

J. W. Kerner, M.D.

8/24, 1931 (Address) **Deputy Coroner**

*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

Washington Park Cem.

9/6 1931

20. UNDERTAKER

C. W. Roberts

ADDRESS

3035 Lucas

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.

