

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

Do not use this space.

33070

1. PLACE OF DEATH

County Registration District No. **1003**
 Township
 City **St. Louis Mo** (No. **3**) **Barnes Hosp.**

File No.
 Registered No. **9965**
 St. Ward)

2. FULL NAME

Nellie Lucas
 (a) Residence, No. **2519a So. 18th** St., **23** Ward.
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **40** 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 **White**
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **April 18 1885**
 7. AGE YEARS **46** MONTHS **5** DAYS **18**
 If LESS than 1 day, hrs. or min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **House Wife**
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

MOTHER FATHER
 13. NAME **Hy. Clawson**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

15. MAIDEN NAME **Not known - Jack**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

17. INFORMANT **Dorothy Brown**
 (ADDRESS) **3720 1/2 Ave**

18. BURIAL, CREMATION, OR REMOVAL

PLACE **Old St. Wrens** DATE **Sept. 26th 1931**

19. UNDERTAKER **Mrs. Schumacher**
 (ADDRESS) **3015 Berenice**

20. FILED **SEP 24 1931** **May E. Standen**
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9-23-1931**

22. I HEREBY CERTIFY, That I attended deceased from **9-11**, 19**31**, to **9-23**, 19**31**

I last saw her alive on **9-23**, 19**31**. Death is said to have occurred on the date stated above, at **5:50 pm**.

The principal cause of death and related causes of importance were as follows:

Acute yellow atrophy of the liver
1250
 Other contributory causes of importance

Name of operation Date of
 What test confirmed diagnosis **Clinical** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify
 (Signed) **James E. Sittings**, M. D.
 (Address) **Barnes Hospital**

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.

