

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

Do not use this space.

33252

1. PLACE OF DEATH

County..... Registration District No. 79
 Townsh..... Primary Registration District No. 00
 City St. Louis (No)..... St. 10184 (Ward)

2. FULL NAME

Maggie Powell

(a) Residence. No. 3119 Lawler Ave. 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 15 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 Maggie Powell
Married

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 1 - 1901

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
<u>30</u>	<u>9</u>	<u>29</u>		

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) Self
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Paris
 (STATE OR COUNTRY) Texas

10. NAME OF FATHER Joe Lee

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

12. MAIDEN NAME OF MOTHER Alice Johnson

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

14. INFORMANT Alice Johnson
 (Address) 3119 Lawler Ave.

15. FILED OCT. 19 1931
 REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 30 1931

17. I HEREBY CERTIFY, That I attended deceased from 8-17 1931, to 9-30 1931 that I last saw him alive on 9-29 1931 and that death occurred, on the date stated above, at 4:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia (Staphylococci)

(duration) yrs. 1 1/2 mos. ds.
 CONTRIBUTORY (SECONDARY) 36
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH Home

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

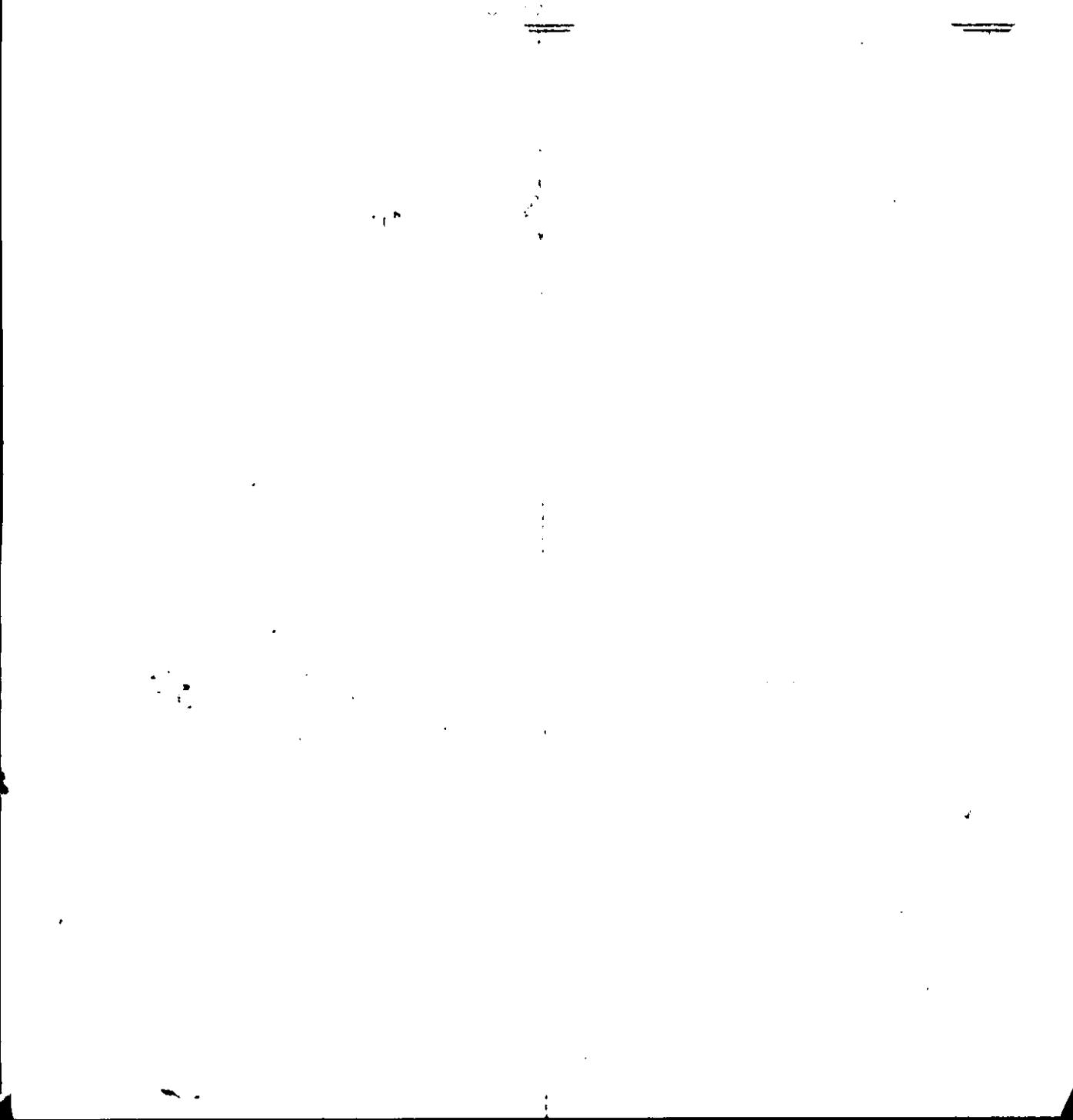
WHAT TEST CONFIRMED DIAGNOSIS? Blood Examination

(Signed) H. S. Leather, M. D.
10/1 19 31 (Address) 3150 E. 20th Ave.

*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 Cem DATE OF BURIAL Oct. 1 1931

20. UNDERTAKER Chas. E. Peter ADDRESS 3030 Bell Ave



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No. St. Ward)

File No.
 Registered No. 10184

2. FULL NAME Maggie Powell

(a) Residence, No. St. 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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 1 - 1901

7. AGE 30 YEARS MONTHS 9 DAYS 29 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19.....

19. UNDERTAKER (ADDRESS)

20. FILED DEC - 1 1901 May @ Starkem Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) sep 30 1931

22. I HEREBY CERTIFY, That I attended deceased from to, 19.....

I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at.....m.

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

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

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), M. D.
 (Address)

SUPPLEMENTARY

ITRARS SHALL NOT RECEIVE A FEE FOR CERTIP ATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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