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.

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

Do not use this space.

35696

File No. .....

Registered No. 10157

1. PLACE OF DEATH

County ..... Registration District No. 1/31

Township ..... Primary Registration District No. .....

City St Louis Mo (No. City Hospital 2 St. ..... Ward)

2. FULL NAME Mabel Clayton

(a) Residence, No. 304 So 7th St., 25 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 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): Widowed

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

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

7. AGE: abt. 58 YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

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. Hwk

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): Missouri

FATHER

13. NAME: Abraham Ball

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

MOTHER

15. MAIDEN NAME: Mary Brown

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

17. INFORMANT (ADDRESS): A. Gertrude Creath City Hospital 2

18. BURIAL, CREMATION, OR REMOVAL
PLACE Father Dickerson DATE 10-3 1931

19. UNDERTAKER (ADDRESS): Watson and Son 2769 Chouteau Ave

20. FILED OCT 2 1931 19 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

2

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-1-, 1931

22. I HEREBY CERTIFY, That I attended deceased from 9-21, 1931, to 10-1, 1931

I last saw her alive on 10-1 55 1931 Death is said to have occurred on the date stated above, at 12 m.

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

	Date of onset
131	
92c	
Chronic Myocarditis	7 years
Chronic Nephritis	

Other contributory causes of importance:

131

Name of operation ..... Date of .....

What test confirmed diagnosis? Autopsy 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) [signature], M. D.

(Address) City Hospital 2