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

Do not use this space.

36130

File No. .....

Registered No. 10655

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1407

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

2. FULL NAME Rebecca Bragg

(a) Residence, No. 4037 Aldrich St., 11 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	Col	Widowed

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.
aft	45	–	–	

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. Work

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) Ga

FATHER

13. NAME Robert Fletcher

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

MOTHER

15. MAIDEN NAME Ellen McKnight

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

17. INFORMANT E Gutzmyle Death
(ADDRESS) City Hospital #2

18. BURIAL, CREMATION, OR REMOVAL
PLACE Jackson Term DATE 10/20 ....19 31

19. UNDERTAKER Chas. J. Geers
(ADDRESS) 4027 Finney Ave.

20. FILED OCT 20 1931 19 Mary E Sturseoff
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-18- 19 31

22. I HEREBY CERTIFY, That I attended deceased from 10-17 ....19 31, to 10-18- 19 31

I last saw her alive on 10-18 ....19 31 Death is said to have occurred on the date stated above, at 11 a m.

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

	Date of onset
23A	
Pulmonary Tuberculosis	

Other contributory causes of importance:

23B

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) C. M. Smith, M. D.

(Address) City Hospital #2

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD