

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

Do not use this space.

42847

**1. PLACE OF DEATH**

County..... Registration District No. *701*  
Township..... Primary Registration District No. *1002*  
City *St. Louis Mo* (No. *4337a*) *Finney* St. .... Ward)

File No. ....  
Registered No. *12773*  
St. .... Ward)

**2. FULL NAME** *Emma Flowers*

(a) Residence. No. *4337a Finney* St., *11* 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 <i>Female</i>	4. COLOR OR RACE <i>colored</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Alores Flowers</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>unknown</i>		
AGE <i>24</i>	YEARS -	MONTHS -
	DAYS -	If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *House wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Clarksville*  
(STATE OR COUNTRY) *Miss.*

**PARENTS**

10. NAME OF FATHER *Thomas Pittman*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Quelwell*  
(STATE OR COUNTRY) *Miss.*

12. MAIDEN NAME OF MOTHER *Carrie Mc. Clain*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *north carolina*  
(STATE OR COUNTRY)

14. INFORMANT *Arnois Pittman*  
(Address) *4337a Finney*

15. FILED *DEC 28 1931*  
REGISTRAR *W. C. Hickey*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12/19* 19*31*

17. HEREBY CERTIFY, That I attended deceased from *Dec 14* 19*31*, to *Dec 19* 19*31*, that I last saw him alive on *Dec 18* 19*31*, and that death occurred, on the date stated above, at *1:30 A.M.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*2357*  
*1913* (duration) yrs. *6* mos. ds.  
CONTRIBUTORY (SECONDARY) *Tobacco* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *1719-52nd St*  
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF *none*

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Special Experiments*  
(Signed) *G. J. J. J. J.* M. D.  
, 19 (Address) *284 V. Easton*

\*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 *Father Dickson* DATE OF BURIAL *Dec. 21 1931*

20. UNDERTAKER *E. M. Tyler* ADDRESS *3029 Pauline*

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.

