

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

Do not use this space.
28126

791
1003

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis mo. City, Hospital # 2 St. Ward)

File No.
Registered No. **8649**
St. Ward)

2. FULL NAME

(a) Residence, No. 4664 Enright St., 12 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 Female 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-10-31

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
		8	7	

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. ml
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) St. Louis mo

FATHER 13. NAME Woble Foster

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

MOTHER 15. MAIDEN NAME Thelma Turner

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

17. INFORMANT a certified death # City Hospital # 2
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Louis Ill DATE 9-1 1922

19. UNDERTAKER Walter Richter
(ADDRESS) 3500 Outpost St

20. FILED SEP 27 1932
City Hospital # 2 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-17-1932

22. I HEREBY CERTIFY, That I attended deceased from 8-4-1932 to 8-17-1932
I last saw him alive on 8-17-1932 Death is said to have occurred on the date stated above, at 10:09 a.m.

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

Other contributory causes of importance: Exhaustion
119 B measles
119 (1)

Name of operation..... Date of.....
What test confirmed diagnosis? Cholera Was there an autopsy? no

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 measles
(Signed) City Hospital # 2
(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.

