

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.

MAR 24 1934

1. PLACE OF DEATH

County Jackson Registration District No. 386  
Township State Primary Registration District No. 1107  
City St. Louis No. 566 St. 2 Ward 683

4959

2. FULL NAME

Charlotte Smith  
(a) Residence, No. 566 Troost St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE negro 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) July 6 - 1852

7. AGE YEARS 82 MONTHS 7 DAYS 3 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

13. NAME unknown

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

15. MAIDEN NAME unknown

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

17. INFORMANT Lucille Smith  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Maple Hill DATE 2/12/34

19. UNDERTAKER H. B. Moore 1820 E-1820  
(ADDRESS)

20. FILED 7/12 1934 M. M. Brown  
Registrar

4 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/9/34

22. I HEREBY CERTIFY That I attended deceased from 2/2/34 to 2/9/34

I last saw him alive on 2/8/34 Death is said to have occurred on the date stated above, at 12 am

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

Gastrointestinal  
Intestinal  
Colic, Stomach  
Pain  
Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Excess of drinking  
metabolism

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? ad Date of injury \_\_\_\_\_, 1934

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) A. J. G. [Signature]

(Address) \_\_\_\_\_

