

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.

OCT 11 1934

791

34295

1. PLACE OF DEATH

County St. Marys Hosp. Registration District No. 1003
 Town St. Louis Primary Registration District No. St. Margt Infirmary
 City St. Louis (No. St. Margt Infirmary) St. _____ Ward _____

File No. _____
 Registered No. 9087

2. FULL NAME

(a) Residence, No. 4210 E. Cook St. Ward. 11
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE C 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) Apr. 13 1892
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 42 4 26
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 5th
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 139

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi
 13. NAME Alec Johnson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okona Miss
 15. MAIDEN NAME Savanna Parchman
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okona Miss

17. INFORMANT Ruth Cheaney
 (ADDRESS) 4210 E. Cook St.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE Sep 13 1934
 19. UNDERTAKER (ADDRESS) 3649 Lindbergh or Park
 20. FILED J. Brebeck Registrar.

5. MEDICAL CERTIFICATE OF DEATH

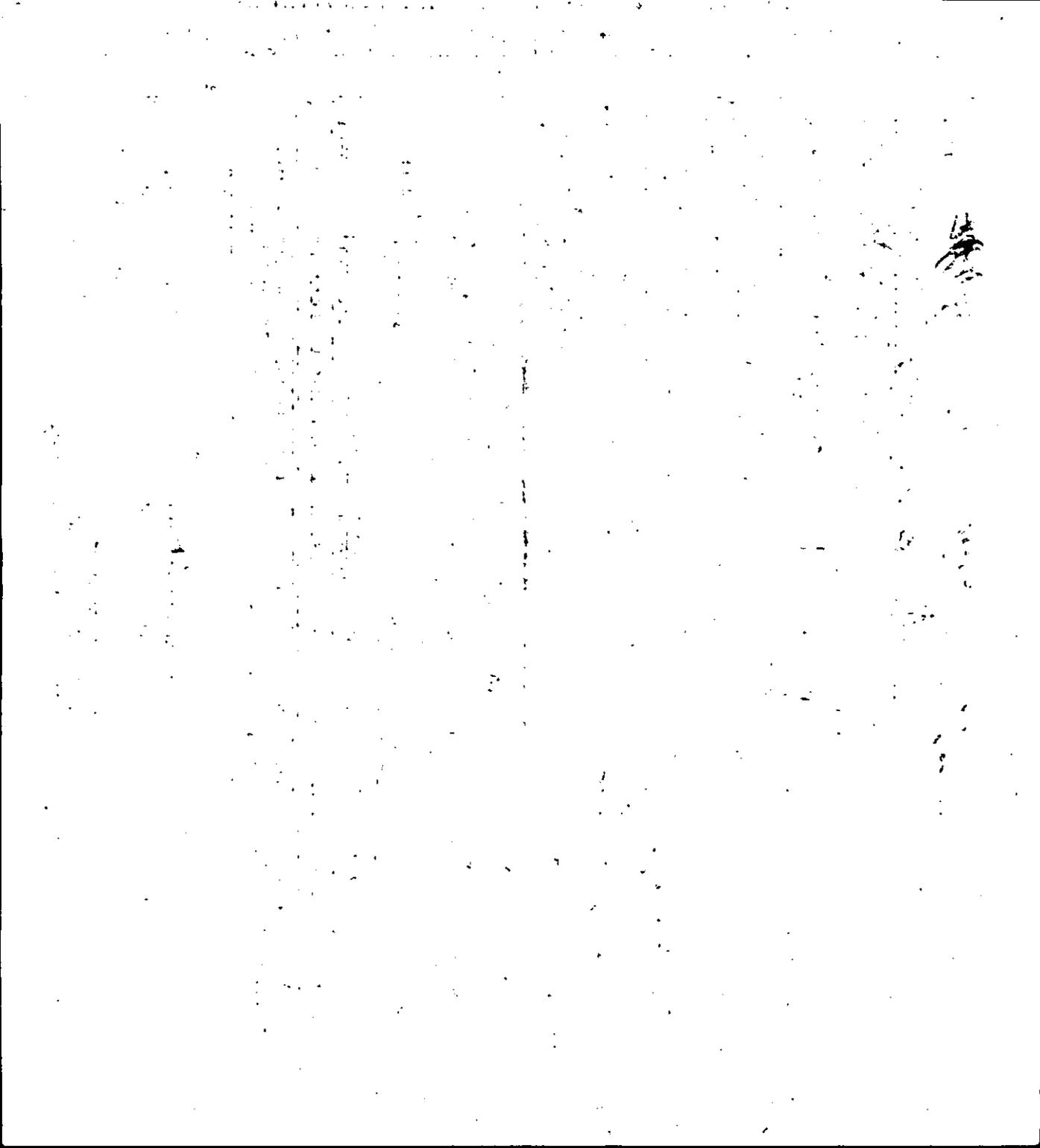
21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 9 1934
 22. I HEREBY CERTIFY, That I attended deceased from 8-7-34, 19____, to 9-8-34, 19____.
 I last saw h. alive on 9-8-34, 19____. Death is said to have occurred on the date stated above, at 4:25 p.m.

The principal cause of death and related causes of importance were as follows:
Post-operative infection
Peritonitis
Paralytic ileus caused by
Hysterectomy performed
 Other contributory causes of importance:
Far from Malgouach
fibroid uterus

Name of operation Hysterectomy Date of 8-31-34
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

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? No
 If so, specify _____
 (Signed) James E. Jackson, M. D.
 (Address) 1536 Papine St.



St Louis City

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Eva Taylor
Who died at St Marys Inf. on Sept 9 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: _____ Years _____ Months _____ Days
Sex F Color or race B Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 42 Months 4 Days 26

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Post-operative infection Peritonitis.
Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) Paralytic Ties Caused by
Birthplace of father (State or country) Hysterectomy performed
Birthplace of mother (State or country) far from male
Principal cause of death: febrile uterus
non-puerperal

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician James E. Jackson
Address of physician 1536 W. Paper St.

Signature of Registrar J. F. Budeck Date filed Oct 29 - 34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McLaugh

State Registrar

Reg. Dist. No.

Primary Reg. Dist. No:

Special Agent.

5-34295