

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.

FEB 2 1 1935

1. PLACE OF DEATH

County _____ Registration District No. **791**
 Townsh _____ Primary Registration District No. **1003**
 City **St. Louis Mo** (No. **City Hospital 2**) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. **4002 - Aldine 11** Ward. _____
 (Usual place of abode) _____ (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **3** 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 **Colored** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Oct. 5th 1904**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	30	2	1	

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. **Nurse-Maid**

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation **8**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**

FATHER 13. NAME **Alex Martin**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**

MOTHER 15. MAIDEN NAME **Jennie Armstrong**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**

17. INFORMANT (ADDRESS) **City Jesu**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St Louis U.** DATE **12-14 1934**

19. UNDERTAKER (ADDRESS) **Walter Richter 3500 Rutledge St**

20. FILED **2 1935** **J. F. Brebeck** Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Dec. 6 1934**

22. I HEREBY CERTIFY, That I attended deceased from **9-16-1934**, to **12-6-1934**. I last saw her alive on **12-6-1934**. Death is said to have occurred on the date stated above, at **2:10 a. m.**

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

Pulmonary Tuberculosis 9-16-34
2.3A

Other contributory causes of importance: **93**

Name of operation _____ Date of _____

What test confirmed diagnosis? **Chemical** 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 _____

(Signed) **Russell Smith** M. D.

(Address) **2945 - Lawton Bldg.**

