

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.

MAR 4 1935

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

Do not use this space.

2719

1. PLACE OF DEATH *St Louis*
County *Hickwood MO* Registration District No. *185*
Township *Hickwood MO* Primary Registration District No. *3037*
City *St Louis* (No. *630* & *Argonne Drive* St. _____ Ward _____)
2. FULL NAME *Essie Lee Ham*
(a) Residence, No. *630 E Argonne Drive* St. _____ Ward _____
(Usual place of abode) (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 *Cold* 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) *1909-11-19*
7. AGE YEARS *25* MONTHS *2* DAYS *4* If LESS than 1 day, hrs. or min.
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. _____
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) *Columbus miss*
13. NAME *Anderson Ham*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Columbus miss*
15. MAIDEN NAME *Sarah Beskwood*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Columbus miss*
17. INFORMANT (ADDRESS) *Arey Strickland 2330 Clark St Louis MO*
18. BURIAL, CREMATION, OR REMOVAL PLACE *Washington* DATE *Jan 30th* 19*35*
19. UNDERTAKER (ADDRESS) *A. L. Best and Co 2726 Lucas Ave*
20. FILED *Jan 30* 19*35* *Agnes C. Keller* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *1-23* 19*35*
22. I HEREBY CERTIFY, That I attended deceased from *11-21* 19*34* to *1-23* 19*35*
I last saw h. *alive* on *1-23* 19*35*. Death is said to have occurred on the date stated above, at *1:30* p. m. The principal cause of death and related causes of importance were as follows:
Acute Pneumonia *Tuberculosis* Date of onset _____
Other contributory causes of importance: *Art. exposure*
Name of operation _____ Date of _____
What test confirmed diagnosis? *2* Was there an autopsy? _____
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? *2* (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. Leo Powell*, M. D.
(Address) *2437 E. Shaw*

