

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.

AUG 9 1935

24711

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis Mo.* (No. *791*)

Registration District No. *791*
Primary Registration District No. *2 1003*
City Hospital No. *2*

File No.
Registered No. *6141*
St. Ward)

2. FULL NAME

(a) Residence, No. *1323 - 7 - Garrison* Ward. *21*
(Usual place of abode)

Length of residence in city or town where death occurred *Life*. 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 <i>Female</i>	4. COLOR OR RACE <i>Colored</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Jan 3 1914</i>		
7. AGE	YEARS <i>19</i>	MONTHS <i>5</i>
	DAYS <i>15</i>	If LESS than 1 day, hrs. or min.
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.		
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) <i>Missouri</i>		
13. NAME <i>Nardy Miller</i>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ill.</i>		
15. MAIDEN NAME <i>Olus Jones</i>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Mo.</i>		
17. INFORMANT (ADDRESS) <i>July DeLoach</i>		
18. BURIAL, CREMATION, OR REMOVAL <i>Greenwood Cem.</i> DATE <i>7/18 1935</i>		
19. UNDERTAKER (ADDRESS) <i>Wm C. McOswell</i> <i>350 05 Franklin Ave</i>		
20. JUL 18 1935 <i>J. J. Probst</i>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 13th 1935*

22. I HEREBY CERTIFY That I attended deceased from *7-6-1935* to *7-15-1935*
I last saw h. *alive* on *7-13-1935*. Death is said to have occurred on the date stated above, at *1:10 P.M.*

The principal cause of death and related causes of importance were as follows:
Yemic Coma
Caused by Chr Nephritis
non purpural

Date of onset *7-6-35*

Other contributory causes of importance: *131*

Name of operation..... Date of.....
What test confirmed diagnosis? *Clinical* 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) *J. B. Harris* M.D.
(Address) *2945 - Lawton Blvd*

