

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.

NOV 2 1935

28290 <sup>2</sup>

1. PLACE OF DEATH

County ..... Registration District No. **791**  
Township ..... Primary Registration District No. **1003**  
City **St. Louis**, (No. **The Peoples Hospital**) St. **8162** Ward

2. FULL NAME

**Genera Guy**  
(a) Residence, No. **1314 Wash** St., **25** Ward.  
Length of residence in city or town where death occurred **25** 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 **F** 4. COLOR OR RACE **Colored** 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) **2-16-1903**

7. AGE YEARS **32** MONTHS **6** DAYS **14** If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **As-work**  
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) **Ill.**

MOTHER FATHER  
13. NAME **Mayou Guy**

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

15. MAIDEN NAME **Comora Pruitt**

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

17. INFORMANT **Peoples Hospital** (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE **St. Louis U** DATE **9-7** 19**35**

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

20. FILED **7** 19**35** **J. B. Beck** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **8-30** 19**35**

22. I HEREBY CERTIFY, That I attended deceased from **8-19** 19**35** to **8-30** 19**35**

I last saw her alive on **8-30** 19**35**, Death is said

to have occurred on the date stated above, at **8:45 P.** m.

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

**Delirium tremens following alcoholism** Date of onset **?**

Other contributory causes of importance:

**Hypertrophic cirrhosis of liver**

Name of operation ..... Date of

What test confirmed diagnosis? ..... 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? **no**

If so, specify

(Signed) **Alan W. Carter**, M. D.

(Address) **Peoples Hospital**

