

FEB 25 1937

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township St. Louis
City J. C. Mo. (No. General Hosp #2)

Registration District No. 3991
Primary Registration District No. 11062

File No. 1579
Registered No. 300
St. 3rd Ward

2. FULL NAME

(a) Residence, No. 1715 Garboe 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 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) 12-31-36

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2

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) J. C. Mo.

13. NAME Wm. (?) Morton 31

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

15. MAIDEN NAME Katherine Turner

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

17. INFORMANT (ADDRESS) Record Clerk

18. BURIAL, CREMATION, OR REMOVAL PLACE Seeds Cemetery DATE January 21, 1937

19. UNDERTAKER (ADDRESS) Wm. Appleton Jones

20. FILE Jan 21 1937 M. M. Browne

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-1, 1937

22. I HEREBY CERTIFY, That I attended deceased from 12-31, 1936 to 1-1, 1937

I last saw him alive on 1-1, 1937. Death is said to have occurred on the date stated above, at 4:48 P.M.

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

Asphyxia
Pallida

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis Clinical 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) J. O. Turner M.D.
(Address) General Hosp #2

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.

1 X7044

