

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. 791

1003

File No. 3951

Township.....

Primary Registration District No. 990

Registered No. 990

City, ST. LOUIS, MO.

(No. CITY HOSPITAL #21)

St. .... Ward)

2. FULL NAME VERNEIL WHITE

(a) Residence, No. 2338 Eugenia St. 22 Ward. 1

(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) July 23rd 1935

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
1 5 27

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Nil

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) ST. LOUIS MO.

13. NAME Samuel Brooks

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

15. MAIDEN NAME Elsie Mae White

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Little Rock Ark.

17. INFORMANT (ADDRESS) Elsie Mae White 2338 Eugenia St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Father Dickson DATE 1-22-37 1937

19. UNDERTAKER (ADDRESS) E. L. GARNER 2829 Washington Ave

20. FILED St. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

No attending physician  
21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 20 1937

22. I HEREBY CERTIFY, That I attended deceased from .., 19.., to .., 19..

I last saw h. .... alive on .., 19.. Death is said

to have occurred on the date stated above, at 8:15 A.m.

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

Labar Pneumonia  
108  
Cholelithiasis, Cholelithiasis  
fract.

Name of operation..... Date of ..

What test confirmed diagnosis?..... 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?..... (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) Joseph M. Zuercher, M.D.

(Address) Deputy Coroner

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.

DEATH RECORD

