LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

37638

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. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. 11051

City St Louis Mo (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Lola Bush

(a) Residence. No. 2645 Bernard St., 7 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 9 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: negro.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Ellis Bush.

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 3/13/1900.

7. AGE: Years 23 | Months 8. | Days 21. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Illinois

PARENTS
10. NAME OF FATHER: J. D. Howell.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ill.
12. MAIDEN NAME OF MOTHER: Isabel Givens
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ill.

14. INFORMANT: Anna F. Woodard
(Address) City Hospital #2

15. FILED DEC -6 1923, 19.. Max C Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12/4 1923

17. I HEREBY CERTIFY, That I attended deceased from 12/1, 1923, to 12/4, 1923, that I last saw her alive on 12/4, 1923, and that death occurred, on the date stated above, at 1.00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. 10 mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical + Lab.

(Signed) L. Comissiony, M. D

12/4, 1923 (Address) City Hospital #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Washington Park
DATE OF BURIAL: Dec 6 1923

20. UNDERTAKER: Watson & Son 2941 Chouteau Ave
ADDRESS

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....,..... St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... 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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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.