

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

Do not use this space.

19472

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **2659**, **Morgan**) St. _____ Ward _____

File No. _____
 Registered No. **5144**

2. FULL NAME

(a) Residence. No. **2659 Morgan** St., **21** 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** | 4. COLOR OR RACE **Colored** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **abt 1860**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
abt 67 | - | - | - | -

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **Minnie Ferguson**
 (Address) **2659 Morgan St.**

15. FILED **101-3 1927** **Marb Starkeoff**
 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 1 1927**

17. I HEREBY CERTIFY, That I attended deceased from **May 14** 19**27** to **6-1-1927**, that I last saw h. s. alive on **May 31** 19**27**, and that death occurred, on the date stated above, at **11:00 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy - Cerebral Hemorrhage
 (duration) yrs. mos. da.

CONTRIBUTORY **Arterio Sclerosis**
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **at home**
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **no** DATE OF _____

WAS THERE AN AUTOPSY? **no**

WHAT TEST COMPLETED DIAGNOSIS? **Clinical**
 (Signed) **Vincent J. Muller, M.D.**

11-2, 1927 (Address) **2335 Franklin**

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Greenwood Cem**
 DATE OF BURIAL **6/3 1927**

20. UNDERTAKER **W. C. Gordon Und. Co**
 ADDRESS **2649 Morgan**

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.

