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

Do not use this space.

19836

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

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

File No.....

Registered No. 5539

2. FULL NAME Alice Sodridge

(a) Residence. No. 1021 N. 10th St., 25 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: Col.

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-6-1864

7. AGE: Years 63 | Months | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER David Johnson

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

12. MAIDEN NAME OF MOTHER Sallie Johnson

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

14. INFORMANT Robert Sodridge
(Address) 4466 Lucas Ave

15. FILED N 16 1927 19 Mae C Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 13 1927

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1926, to June 7, 1927, that I last saw h. alive on June 7, 1927, and that death occurred, on the date stated above, at 5 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma Uterus

46 (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) W. Thom, M. D

, 19 (Address) 3500 Olive

*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

DATE OF BURIAL: 6 17 1927

20. UNDERTAKER: F.W. Hughes

ADDRESS 2626 Lawton

WHITE 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.