

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

Do not use this space.

28382

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis, Mo.** (No. **18 20 22**) St. _____ Ward _____
 Registered No. **7902**

2. FULL NAME

Julia Allen
 (a) Residence. No. **18 South 22nd St.** **2A** 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 **negro** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **abt. 1871**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
About 56

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **House 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) **North Carolina**

10. NAME OF FATHER **Not known**

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

12. MAIDEN NAME OF MOTHER **Not known**

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

14. INFORMANT **Mamie Owens**
 (Address) **18 South 22 St**

15. FILED **SEP -6 1927** **Max G. Staroboff** Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **9-1-1927**

HEREBY CERTIFY That I attended deceased from **July 1927** to **Sept 1, 1927**
 I last saw **her** alive on **Sept 1, 1927** and that death occurred, on the date stated above, at **2-302**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ecdocarditis, Acute
 (duration) yrs. **2** mos. da.

CONTRIBUTORY (SECONDARY) **Ch. Rheumatism, Acute**
 (duration) yrs. **2** mos. da.

18. WHERE WAS DISEASE CONTRACTED **At place of residence**
 IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____
 WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **W. H. ... M. D.**
 , 19 (Address) **2105 1/2 Market**

*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 **Sept 6 1927**

20. UNDERTAKER **A. L. Deal** ADDRESS **2726 Lucas**

A. E.—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.

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