

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

Do not use this space.

32293

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **2605** **Blair**)

St. **W.** (Ward)

File No.

Registered No. **9705**

2. FULL NAME **Houston Troupe**

(a) Residence. No. **2605 Blair** St., **W.** Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yr. mos. ds.

How long in U.S., if of foreign birth?

yr. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 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 **Ella May Troupe**

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
abt 26				

8. OCCUPATION OF DECEASED

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

labor

(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

Jose Troupe

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss.

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14.

INFORMANT **Ella May Troupe**
(Address) **2605 Blair**

15.

FILED **30** 19**27**

mar 6

Barlow

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 26th 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Oct 3**, 19**27**, to **Oct 26**, 19**27** that I last saw him alive on **Oct 26**, 19**27**, and that death occurred, on the date stated above, at **St. Louis**.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

11 03 / 10 10
(duration) yr. mos. **7** ds.

CONTRIBUTORY (SECONDARY)

Pleurisy
(duration) yr. mos. **16** ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH... No. DATE OF.....

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Auscultation**

(Signed) **J. A. Flowers** M. D.

, 19**27** (Address) **1711 N. 10th St.**

*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

DATE OF BURIAL

Greenwood

1931 1927

20. UNDERTAKER

ADDRESS **3036**

C. W. Roberts Lucas

COPY, 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.

