

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

Do not use this space.

38544

1. PLACE OF DEATH

County..... Registration District No. 791
 Township St. Louis City Registration District No. 1003
 City St. Louis (No. City Hospital #2)

File No.
 Registered No. 11224
 St. Ward)

2. FULL NAME

(a) Residence. No. 1306 Wash 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 21, 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
1 22

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

Nil

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

10. NAME OF FATHER Walter Wilson

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

12. MAIDEN NAME OF MOTHER Lula Carter

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

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

15. FILED DEC 16 1927 max @ Starkeoff
 19 _____ REGISTERAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 12/11, 1927, to 12/13, 1927 that I last saw her alive on 12/13, 1927, and that death occurred, on the date stated above, at 5:00 a. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Lobar Pneumonia
108

about 10:00 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED not known
 IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS autopsy
 (Signed) Chas. J. Soule, M. D.
 .19 (Address) City Hosp. #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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greenwood Cemetery DATE OF BURIAL 12/16 1927

20. UNDERTAKER Chas. E. Keth ADDRESS 3080 Belle

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.

