

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

Do not use this space.

38860

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis* (No.)

Registration District No. **791**
1003
Primary Registration District No.

File No.
Registered No. **11597**
St. Ward)

2. FULL NAME

(a) Residence. No. *2327 Clark* St., *22* Ward

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *4* 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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 26, 1909*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *18 | 3 | 27*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Nursework*
(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 *Steve Eskridge*

11. BIRTHPLACE OF FATHER (CITY OR TOWN); (STATE OR COUNTRY) *Ala.*

12. MAIDEN NAME OF MOTHER *Rose Nelson*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN); (STATE OR COUNTRY) *Ala.*

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

15. FILED *DEC 27 1924* 19 *24* *Maude Starkeoff* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec. 23, 1927*

17. I HEREBY CERTIFY That I attended deceased from *12/22*, 19*27*, to *12/23*, 19*27*, that I last saw him alive on *12/22*, 19*27*, and that death occurred, on the date stated above, at *9:45* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary tuberculosis

Indefinite (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *31* (duration) yrs. mos. da.

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

0 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *R. J. Howell*, M. D. (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 *Booker Washington Cem* DATE OF BURIAL *Dec 29, 27*

20. UNDERTAKER *H. M. Brown* ADDRESS *3577 Locbl*

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.

