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

Do not use this space.

10666

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City St Louis (No. City Hospital #2 ..... St. ..... Ward)

File No. .....

Registered No. 2411

2. FULL NAME Emma Tarth

(a) Residence. No. 2745a Walnut St., 22 Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 3 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) Jan. 28 1892

7. AGE: Years 36 Months 1 Days 4 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Domestic
(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.

PARENTS

10. NAME OF FATHER: Clay Brown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Miss
12. MAIDEN NAME OF MOTHER: Emma Shackelford
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ga

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

15. FILED ..... 19..... Mar C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 2, 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1928, to March 2, 1928 that I last saw her alive on March 2, 1928, and that death occurred, on the date stated above, at 6:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pulmonary Tuberculosis 23A

about (duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

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

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) R. C. Howell, M. D

3/3, 1928 (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: Little Rock, Ark

DATE OF BURIAL: Mar. 5 1928

20. UNDERTAKER: J. H. Harrison

ADDRESS 2906 Lawton Blvd.

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.