

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis Mo.* (No. *City Hosp # 2*)

Registration District No. **791**
1003

Primary Registration District No.

File No. **14891**
Registered No. **3794**
St. Ward)

2. FULL NAME

(a) Residence. No. *2338 1/2 market St.* **12th** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **2** 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)

married

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

X *Reiouds Bailey*

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

not known

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

about 23

8. OCCUPATION OF DECEASED

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

Housewife

(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)

Jackson Miss

10. NAME OF FATHER

Primus Wells

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

not known

14.

INFORMANT (Address)

Reiouds Bailey 2338 1/2 market St

15.

APR -5 1928 FILED

Wm C Starks REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

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

4-1-28 19

17.

I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Peritonitis following abortion cause by fall down steps

CONTRIBUTORY (SECONDARY)

Accident

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *Wm Dyer* M.D.

4/3 1928 (Address) *424 Coroner*

*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

Washington Park Cem *April 6 1928*

20. UNDERTAKER

ADDRESS

Wm Brod. *Jeff ave*

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.

