

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

Do not use this space.

29054

1. PLACE OF DEATH

County..... Registration District No. *18*
Township..... Primary Registration District No. *18*
City *St. Louis* (No. *908 Cass*)

File No.
Registered No. *8560*
St. Ward)

2. FULL NAME

(a) Residence. No. *908 Cass* 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. 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, WIDOWED, OR DIVORCED—HUSBAND OF (or) WIFE OF *Frank Phillips*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *7-6-1886*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 | *1* | *13* | *2 3/4*

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *house work*
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Marville, Ark.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Alex Peterson*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Marville, Ark.*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Cornelesse Luchins*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Marville, Ark.*
(STATE OR COUNTRY)

14. INFORMANT *Cornelesse Peterson*
(Address) *908 Cass Ave.*

15. FILED *21*, 19 *May* *C Starkoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 19* 19*28*

17. I HEREBY CERTIFY That I attended deceased from *July 8*, 19*28*, to *Aug 6*, 19*28*
(that I last saw her alive on *Aug 6*, 19*28*, and that death occurred, on the date stated above, at *2 3/4* m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
3

CONTRIBUTORY *Bronchitis acuta*
(SECONDARY) *Tubercular* (duration)..... yrs. mos. ds. *15*

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, *Dont know*

19. DID AN OPERATION PRECEDE DEATH? *no* DATE of.....

20. WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS? *Laboratory test*
(Signed) *Jay H Lamb*, M. D.
, 19 *(Address) 1332 Franklin Ave*

*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 *Father Dickson* DATE OF BURIAL *8-24-1928*

20. UNDERTAKER *B. Leonard and Co.* ADDRESS *2702 Hunt*

R. E.—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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

