

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

Do not use this space.

32395

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 100B
City St. Louis (No. City Hospital #2)

File No.
Registered No. 10396
St. Ward)

2. FULL NAME

(a) Residence. No. 1213 St. Bernard 18 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 Male 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 14, 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 5 hrs. 25 min.

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 _____

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

10. NAME OF FATHER Vernice Daniels

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

12. MAIDEN NAME OF MOTHER Estelle Pirtle

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

14. INFORMANT Marjorie Woodard
(Address) City Hospital #2

15. FILED 21 1928 Max B. Starckoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-15-1928

17. I HEREBY CERTIFY, That I attended deceased from 1:30 AM 9-15- 1928, to 7:10 AM-9-15- 1928 that I last saw h.i.m. alive on 9-15- 1928, and that death occurred, on the date stated above, at 7:10 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Delivery
16/10/16 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. G. Cunningham M. D.

, 19 (Address) 2945 Lambert

*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 POTTERS FIELD. DATE OF BURIAL 21 25 1928

20. UNDERTAKER R. Wilson 2945 Lambert ADDRESS

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.

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