

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

Do not use this space.

29576

**1. PLACE OF DEATH**

County.....

Registration District No.....

791  
1003

Township.....

Primary Registration District No.....

File No.....

City St. Louis, Mo. (No. City Hospital # 2)

Registered No. 8763

St. .... Ward)

**2. FULL NAME**

Annie Smith

(a) Residence. No. 817 St. 18 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 50 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)

wid.

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

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

unknown

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, .... hrs. or .... min.

abt. 52 — —

8. OCCUPATION OF DECEASED

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

Laundress

(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)

Ill.

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT

(Address)

FILED

a. Gertrude Creath  
City Hospital # 2  
Wm. C. Washburn

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

8-23-1929

17.

I HEREBY CERTIFY, That I attended deceased from 8-7-29 to 8-8-29 that I last saw h. et. alive on 8-23-1929 and that death occurred, on the date stated above, at 7:20 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Tuberc Dorsalis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRIBUTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

8/26/1929 (Address) City Hospital # 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

DATE OF BURIAL

Greenwood

8/27 1929

20. UNDERTAKER

ADDRESS

Dement & Sons

2700 Wash St

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.

RECORD

