

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

Do not use this space.

42547

1. PLACE OF DEATH

County..... Registration District No. **701**
1003

Township..... Primary Registration District No.

City **St. Louis, mo** (No. **City Hospital # 2**)

File No.

Registered No. **12312**

St. Ward)

2. FULL NAME

(a) Residence. No. **Baby** **McField** St. **11** 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. **12** ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

11-26-29

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

-

-

12

8. OCCUPATION OF DECEASED

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

Inf

(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 **Wm. McField**

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

12. MAIDEN NAME OF MOTHER **Luna Ballard**

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

14. INFORMANT **A. Bertruda Creath**
(Address) **City Hospital # 2**

15. FILED **DEC 23 1929** **Max C. Standley** REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) **12-8-1929**

17. I HEREBY CERTIFY, That I attended deceased from **11-26-29** to **12-8-29** that I last saw him alive on **12-8-29** and that death occurred, on the date stated above, at **7 AM** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

159

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **A. K. Hale** M. D.

12/11/29 (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

CITY HOSPITAL

12-19-1929

20. UNDERTAKER

ADDRESS

Lory Astor 5945 Lawton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

