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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 42802

Township ..... Primary Registration District No. ..... Registered No. 12591

City ..... (No. ISOLATION HOSPITAL St. ..... Ward)

2. FULL NAME Corrine (Dorsie) Dorsie

(a) Residence. No. 2223 Franklin St., 21 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	colored	~~Separated~~ Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May. 3 - 1911

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
18		7	17	

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

261

9. BIRTHPLACE (CITY OR TOWN) unknown
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT C. Sheridan
(Address) ISOLATION HOSPITAL

15. FILED DEC 27 1929 19.. Mar C Hankins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 20 1929

17. I HEREBY CERTIFY, That I attended deceased from 12-9, 1929, to 12-20, 1929, that I last saw her alive on 12-19-, 1929, and that death occurred, on the date stated above, at 5 35 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

23A Pulmonary Tuberculosis

31

13C

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chr Myocarditis

Chr Nephritis (duration) ? yrs. ..... mos. ..... ds.

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? Clinical + Xray

(Signed) Henry J Ulrich, M. D.

12-20, 1929 - (Address) ISOLATION HOSPITAL

*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	12/27 1929
20. UNDERTAKER	ADDRESS
Ellis Jones	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.

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