

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

Do not use this space.

**27066**

**1. PLACE OF DEATH**

Country..... Registration District No. **1001**  
 Township..... Primary Registration District No. **1001**  
 City **St. Louis Mo.** (No. **Barnes Hospital**) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME Elizabeth Daniels**

(a) Residence, No. **5853 Julian** St., **6** 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 **Colored** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**

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. 50**

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Domestic**  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**

FATHER 13. NAME **Billy Carr**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**

MOTHER 15. MAIDEN NAME **Caroline Spencer**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**

17. INFORMANT (ADDRESS) **Sophorna Boyer 5853 Julian**

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE **Arthur Jackson 7-31-1931**

19. UNDERTAKER (ADDRESS) **L. O. Atkins 331 Morgan St**

20. FILED **LL 38 1931** Registrar

**2 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7-26-1931**

22. I HEREBY CERTIFY, That I attended deceased from **7-17-1931**, to **7-26-1931**

I last saw him alive on **7-26-1931**. Death is said to have occurred on the date stated above, at **12:00 a.m.**

The principal cause of death and related causes of importance were as follows:

**Sub-Arachnoid Hemorrhage**  
**874 JWA**  
**102**  
 Other contributory causes of importance:  
**Hypertension**

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify

(Signed) **A. N. Carnegie** M. D.

(Address) **Barnes Hospital**

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

