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

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.

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

Do not use this space.

File No. 35822

Registered No. 10336

**1. PLACE OF DEATH**

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis Mo (No. City Hospital 2 St. ..... Ward)

**2. FULL NAME** Vineda Perkins

(a) Residence, No. 2815 Stoddard 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 11 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): Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 6-22-1902

7. AGE: YEARS 29 | MONTHS 3 | DAYS 13 | If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housewife

10. Date deceased last worked at this occupation (month and year) unknown

11. Total time (years) spent in this occupation unknown

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Miss

FATHER

13. NAME: Mose Cohen

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Miss

MOTHER

15. MAIDEN NAME: Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Miss

17. INFORMANT (ADDRESS): A. Gertrude Creath City Hospital #2

18. BURIAL, CREMATION, OR REMOVAL
PLACE Washington Park DATE 10/8/1931

19. UNDERTAKER (ADDRESS): Peoples Und Co 3100 Franklin Av

20. FILED OCT -8 1931 19 Max [illegible] Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 10-5-, 1931

22. I HEREBY CERTIFY, That I attended deceased from 9-18, 1931, to 10-5, 1931

I last saw her alive on 10-5, 1931. Death is said to have occurred on the date stated above, at 5:45 P m.

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

| | Date of onset |
|---|---|
| 23A | |
| Pulmonary Tuberculosis | 6 month |

Other contributory causes of importance:

23

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

What test confirmed diagnosis? Autopsy 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) C. M. Smith, M. D.

(Address) City Hospital #2