

DEC 1 3 1934

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

Do not use this space.

41039

1. PLACE OF DEATH

County..... Registration District No. *791*
Township..... Primary Registration District No. *2012*
City *St. Louis, Mo. 43* *Marnice Place* St. Ward)

File No.
Registered No. *10988*

2. FULL NAME

(a) Residence, No. *3043 Marnice Place* 10 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred *15* 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 *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan. 30-1918*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
16 10 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *School girl*
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 *Jacob Rhodes*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Alabama*

MOTHER 15. MAIDEN NAME *Williama Phillips*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Alabama*

17. INFORMANT *Williama Rhodes*
(ADDRESS) *3043 Marnice Pl*

18. BURIAL, CREMATION OR REMOVAL PLACE *Galley, Jackson* DATE *11/18*, 19 *34*

19. UNDERTAKER (ADDRESS) *Charles E. Peters*
3030 Bell Ave

20. FILED *117* 19 *34* Registrar. *Peters Funeral Home*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *November 15, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *Oct/27/34* 19 to *Nov/15/34* 19

I last saw *her* alive on *Oct/27/34* 19. Death is said to have occurred on the date stated above, at *3 P.M.*

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

Pneumonia Pulmonalis Date of onset *few mos.*

Other contributory causes of importance *25*

Name of operation Date of
What test confirmed diagnosis? *Microscope* Was there an autopsy? *NO*

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? *NO*
If so, specify

(Signed) *A. Brode* M. D.

(Address) *1336 Franklin, St. Louis Mo*

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 PRINTLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

