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.

SEP 10 1937

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

Do not use this space.

29105

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City St Louis Mo. (No. 2729 A Stoddard St St. ..... Ward)

File No. .....

Registered No. 7738

2. FULL NAME Lou Spiviy

(a) Residence, No. 2729 A Stoddard St St., 21 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 5 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: Widow

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): June 2nd 1863

7. AGE: YEARS 74 MONTHS 2 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. Domestic

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): Athens Ga;

FATHER

13. NAME: Will Graham

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ga;

MOTHER

15. MAIDEN NAME: Unknown

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

17. INFORMANT (ADDRESS): Loytie Bailey

18. BURIAL, CREMATION, OR REMOVAL

PLACE Father Nickson DATE 8-18 1937

19. UNDERTAKER (ADDRESS): Ellis Funeral Home 2820 Stoddard St

20. AUG 17 1937 19 J F Bieleck Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-15-37, 19

22. I HEREBY CERTIFY, That I attended deceased from May 20th 1937, to Aug-15, 1937

I last saw him alive on Aug 15th 1937 Death is said to have occurred on the date stated above, at 11:30 a.m.

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

Cerebral Hemorrhage (apoplexy) — Date of onset 2 days

Other contributory causes of importance: Chronic Interstitial Nephritis — 2 yr.

Name of operation no Date of .....

What test confirmed diagnosis? — 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?

If so, specify .....

(Signed) T J Jones, M. D.

(Address) 2330 Franklin