Place of Death: Texas

State: Texas

County: 

City or Precinct No.: 

Residence of the Deceased: 

Date of Death: 3/15/1937

Date of Birth: 4/10/1921

Sex: Female

Color or Race: White

Marital Status: Single

Caused of Death: Tuberculosis

Medical Certificate of Death:

Name of Operation: 

Date of: 

What test confirmed diagnosis? 

Was there an autopsy? 

Accident, suicide, or homicide? 

Date of Injury: 3/15/1937

Place of Injury: Dallas Co. 

Manner of Injury: Exploded

Nature of Injury: 

Registration:

Registrar's No.: 

File Date: 3-25-37