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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 30734

or

Village ..... Primary Registration District No. 1003 Registered No. 8638

or

City St. Louis Mo. (NO. Sanitarium St.; N Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Stephen Dolson.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Jan. (Month) 20 (Day), 1839 (Year)

7 AGE: 79 yrs. 7 mos. 26 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): Unknown

9 BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): New York

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A C Vickrey

(Address) 5400 Arsenal

15 Filed SEP 15 1918, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: September (Month) 14 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 1, 1918, to September 14, 1918, that I last saw him alive on September 14, 1918, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

82 A

77

64

(Duration) ..... yrs. 9 mos. 8 + ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 21 ds.

(Signed) A C Vickrey M. D.

Sept 14, 1918 (Address) 5400 Arsenal

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. 9 mos. 8 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence 4541a Harris St

19 PLACE OF BURIAL OR REMOVAL: S. S. Peter & Paul

DATE OF BURIAL: Sept. 17, 1918

20 UNDERTAKER: Wm. F. Paschedag

ADDRESS: 2825 N. Grand Av

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

7 AGE .....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ....., 191..... (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....

that I last saw h.....alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs.....mos.....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS