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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 30756

or

Village ..... Primary Registration District No. 1003 Registered No. 8664

or

City S Louis (NO. City Hospital 25 Ward)

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

2 FULL NAME Edw Cadwallady 7179

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Oct (Month) 18 (Day) 1891 (Year)

7 AGE: 27 yrs. 10 mos. 28 ds. If LESS than 1 day, ..... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER: David Cadwallady

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

12 MAIDEN NAME OF MOTHER: Emma Barker

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Information O'Rowan

(Address) City Hospital

15 Filed SEP 16 1911 191 Max C Starkloff Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: Sept (Month) 15 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 11, 1918, to Sept 15, 1918, that I last saw him alive on Sept 15, 1918, and that death occurred, on the date stated above, at 5:10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease
Aortic regurgitation

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

CONTRIBUTORY (Secondary) Dilatation of heart

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

(Signed) Emil Heim M.D.

Sept 15 1918 (Address) City Hospital

*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. 4 ds. In the State 27 yrs. ..... mos. ..... ds.

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

Former or usual residence 4949 Forest Park Boul

19 PLACE OF BURIAL OR REMOVAL: Bethania

DATE OF BURIAL: Sept 18 1918

20 UNDERTAKER: Geo L Fleitsch

ADDRESS: 5966 Easton

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

**1 PLACE OF DEATH**

County .....

Township ..... or Village ..... or City ..... — Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

(NO. ..... St.; ..... Ward)

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

**2 FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

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

**6 DATE OF BIRTH**

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

**10 NAME OF FATHER**

**PARENTS**

**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) ..... (Day), 191..... (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, (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. .....

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** |