MARGIN RESERVED FOR BINDING

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. 781 File No. 30773

or

Village ..... Primary Registration District No. 1003 Registered No. 8681

or

City St. Louis (NO. St. Mary's Infirmary St.; 1 Ward)

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

2 FULL NAME James M. Combs

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 August (Month) 28 (Day) 1852 (Year)

7 AGE 66 yrs. X mos. 19 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): —

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

PARENTS

10 NAME OF FATHER Theodore Combs

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

12 MAIDEN NAME OF MOTHER Elizabeth Thompson

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wesley Noel

(Address) 6288a Bartmer

15 Filed SEP 27 1918 Max C Starkloff, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 16 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from 8/17, 1918, to 9/16, 1918, that I last saw him alive on 9/15, 1918, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

120

(Duration) ..... yrs. about 9 mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis (chronic)

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

(Signed) O. W. Thig M. D.

9/16, 1918 (Address) 1536 Pine

*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 X yrs. X mos. 5 ds. In the State About 60 years yrs. ..... mos. ..... ds.

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

Former or usual residence 6726 Olive St. road St. Louis Co. Mo.

19 PLACE OF BURIAL OR REMOVAL Valhalla Cemetery **DATE OF BURIAL** Sept. 18, 1918

20 UNDERTAKER Elmer Shepard **ADDRESS** 5921 Easton Ave.

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 .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write the word*)

6 DATE OF BIRTH
..... 1.....
(Month) (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
..... , 191.....
(Month) (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

V. S. No. 2. A

MARGIN RESERVED FOR BINDING

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.