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. 30853

or

Village ..... Primary Registration District No. 1003 Registered No. 8782

or

City St. Louis Mo. (NO. Sanitarium St. 16 Ward)

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

2 FULL NAME Fred Scales

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

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

6 DATE OF BIRTH: Mar. (Month) 15 (?) (Day), 1854 (Year)

7 AGE: 64 yrs. 6 mos. 5 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): Atlanta, Ga.

PARENTS

10 NAME OF FATHER: Unknown

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) Geo A Johns

(Address) Sanitarium

15

Filed [illegible] 20 [illegible] 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: September (Month) 19 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from September 6, 1918 to September 19, 1918, that I last saw him alive on September 19, 1918, and that death occurred, on the date stated above, at 5:20 a m.

The CAUSE OF DEATH* was as follows:

69

Dementia Paralytica

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary): Abscess of Scalp

(Duration) ....yrs. ....mos. 4 ds.

(Signed) Geo A Johns M. D.

Sept 19, 1918 (Address) Sanitarium

*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. 14 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence 2617 Bernard St.

19 PLACE OF BURIAL OR REMOVAL: Greenwood

DATE OF BURIAL: Sept. 22, 1918

20 UNDERTAKER: Harrison McKoin

ADDRESS: 2906 Lawton av.

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

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.

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

..... (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)

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) ..... (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, 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