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 ..... or Village ..... or City St. Louis (NO. 2838 Olive St.; 17 Ward)

Registration District No. 791 File No. 31046

Primary Registration District No. 1003 Registered No. 8993

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

2 FULL NAME Geo. P. Drew

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Unknown (Month) (Day) 1845 (Year)

7 AGE: Abt. 73 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

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) H. W. Fath
(Address) Coroners Office

15 Filed SEP 28 1918, 19.. Max C. Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 6th (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from March, 1918, to Sept 6th, 1918, that I last saw him alive on Sept 6th, 1918 and that death occurred, on the date stated above, at 9-00 a.m.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis (Heart disease)
93 A
(Duration) ..... yrs. 8 mos. ..... ds.

OK H. W. Fath Dep. C.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas A Wood M.D. M. D.
9/9, 1918 (Address) 3904 Delaware Ave

*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 2838 Olive St.

19 PLACE OF BURIAL OR REMOVAL: Wesleyan Cemetery
DATE OF BURIAL: Sep 30, 1918

20 UNDERTAKER: Geo W Fish
ADDRESS: Clayton M.

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

....., 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**

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.

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