

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

Do not use this space.

10298

1. PLACE OF DEATH

County.....
Township.....
City St. Louis

Registration District No. 191
Primary Registration District No. 1003
(No. Mo. Baptiste Sanatorium)

File No.....
Registered No. 3324
St. Ward)

2. FULL NAME

(a) Residence. No. Russel A. Whittaker
(Usual place of abode) 219 Courtland Ave. St. 9 Ward.

St. Louis Co. Mo.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 26 1915

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
9 7 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Albert Whittaker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ills
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Pauline Bickell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Chas A Bickell
(Address) 1213 Buchner Ave

15. FILED 30 1925 Mar 6 Starloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 29 1925

17. I HEREBY CERTIFY That I attended deceased from Mar 12 to Mar 29 1925
that I last saw him alive on Mar 29 1925, and that death occurred, on the date stated above, at 11402 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Meningitis (Streptococci)
GAC non Epidemic

CONTRIBUTORY (SECONDARY) Suppurative Otitis Media

18. WHERE WAS DISEASE CONTRAICTED (duration) yrs. mos. da.
IF NOT AT PLACE OF DEATH 219 Courtland St. St. Louis

DID AN OPERATION PRECEDE DEATH? No DATE OF 2

WAS THERE AN ANESTHETIC? No

WHAT TEST CONFIRMED DIAGNOSIS? Lumbar puncture
(Signed) W. F. Paschedag M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Zions DATE OF BURIAL Mar 30 1925

20. UNDERTAKER Wm F Paschedag ADDRESS 2825
70 Grand Bl

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.

