

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

Do not use this space.

40324

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City..... (No. *11174*)

Clay (City) *Weptha*

File No.....

Registered No. *12368*

St. Ward)

2. FULL NAME

(a) Residence. No. *3 Lucas* St., *25* Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *80* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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)

Unknown

7. AGE

abn 80

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

Labor

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

Ch. Maria Clay Weptha

15.

FILED *DEC 30 1926*

Max B. Staroboff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 20 1926*

17. I HEREBY CERTIFY, That I attended deceased from *Nov 27*, 19*26*, to *Dec 20*, 19*26*, that I last saw him *live* on *Dec 20*, 19*26*, and that death occurred, on the date stated above, at *1240 h.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:
Right Lobar Pneumonia, Hypertrophy of Prostate causing incomplete retention of urine

CONTRIBUTORY *Senility* (SECONDARY) (duration) *11* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED (duration) *137* yrs. mos. ds.

IF NOT AT PLACE OF DEATH.....

Did an operation precede death?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *Geo. Staker*, M. D.

12/20, 19*26* (Address) *Clay Weptha*

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Washington D. DATE OF BURIAL *12/27 26*

20. UNDERTAKER ADDRESS

W. Richter 3500 Kedge

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.

Hail