

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

Do not use this space.

1180
207

1. PLACE OF DEATH

County Lackman
Township St. Louis
City St. Louis (No. 8785 East 15th)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 8785 East 15th St., _____ Ward _____
(Usual place of abode)

(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 Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 1 - 1926

7. AGE YEARS MONTHS DAYS 1 13 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(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 Clarence Sexton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Della Roberts

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

14. INFORMANT Mae Roberts
(Address) 1600 Thiller

15. FILED 44 1927 M.M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 13 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Jan 13, 1927 that I last saw him alive on Jan 12, 1927, and that death occurred, on the date stated above, at 7:22 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Incomplete closure of
foramen ovale
1570
1180 (duration) yrs. mos. da.

CONTRIBUTORY Acute Indigestion
(SECONDARY) (duration) yrs. mos. da. 3

18. WHEN WAS DISEASE CONTRACTED 15913
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? ✓
(Signed) W.R. Foster, M. D.
1-14, 1927 (Address) 1029 Litch

*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 Brookings Cem DATE OF BURIAL Jan 15 1927

20. UNDERTAKER Rose & Co 15th ADDRESS Lackman

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.

For [unclear]

[unclear]