

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

Do not use this space.

2088

791

51013

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City St. Louis (No. Barnes Hospital)

File No.
Registered No. 252
Sl. Ward

2. FULL NAME

(a) Residence. No. R.R.#5, Box 593 of 12 Ward, Kirkwood Mo
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

Harvey Craig

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

May 22, 1886

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>40</u>	<u>7</u>	<u>15</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Chicago, Illinois

10. NAME OF FATHER

James A. Tower

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

New York

12. MAIDEN NAME OF MOTHER

Laura Semons

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

Brooklyn, New York

14.

INFORMANT (Address), Harvey Craig, Kirkwood Mo.

15.

JAN 19 1927
Mar 6 Starckoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 6 1927

17. I HEREBY CERTIFY That I attended deceased from 1-4, 1927, to 1-6, 1927 that I last saw him alive on 1-6, 1927, and that death occurred, on the date stated above, at 9:55 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chc. Hepatitis
Terminal pneumonia
Hypertension
From the Pneumonia

CONTRIBUTORY (SECONDARY) ceramias
(Duration) 11 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Geo. Kuesche, M. D.

, 19 (Address) Barnes Hosp.

*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 **DATE OF BURIAL**

Valhalla Crematory Jan 8 1927
20. UNDERTAKER Webster
Parker Dead Co Graves

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.

