

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

Do not use this space.

2089

**1. PLACE OF DEATH**

County..... Registration District No.....  
Township..... Primary Registration District No.....  
City St. Louis (No. 407 S. Ewing)..... St. .... (Ward)

File No.....  
Registered No. 253.....

**2. FULL NAME**

Eugene White  
(a) Residence. No. 407 S. Ewing St. .... Ward. ....  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, — hrs. — min.
<u>46</u>	<u>?</u>	<u>?</u>	<u>?</u>	<u>—</u>

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

PARENTS

10. NAME OF FATHER John White  
11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY).....  
12. MAIDEN NAME OF MOTHER Mandy ?  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY).....

14. INFORMANT (Address) James Ward  
407 S. Ewing

15. FILED JAN - 7 1927 Mary B. Starkeoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 - 1927

17. I HEREBY CERTIFY That I attended deceased from Dec 20 - 1926 to Jan 5 - 1927, that I last saw him alive on Dec 20 - 1926, and that death occurred, on the date stated above, at 8:00 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Lobar Pneumonia

108  
1108 1010  
CONTRIBUTORY (SECONDARY) pleurisy  
(duration) yrs. mos. ds. 1 mos. — ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF.....  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? Symptoms  
(Signed) Dr. W. J. Doherty M. D.  
, 19 (Address) 11 - N. Jefferson

\*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 Park DATE OF BURIAL 1-9-1927

20. UNDERTAKER Gott's Und. Co. ADDRESS 4107 Piney

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.

