

MISSEISSIPPI BOARD OF HEALTH
 DEPARTMENT OF STATISTICS
 CERTIFICATE OF DEATH

Do not use this space.

✓ 3001

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City No. 2013 *St Louis* (No. *City Hospital*)

File No. 592

Registered No. 2

St. _____

Ward _____

2. FULL NAME

(a) Residence. No. 20 *Regina* St. *St. Louis* Mo. (Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 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)

Aug 28 - 1887

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
29	4	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *News agent*

(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) *Missouri*

10. NAME OF FATHER

Don McKee

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Ohio*

12. MAIDEN NAME OF MOTHER

Hester

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Illinois*

14.

INFORMANT

(Address)

R. M. Smith
City Hospital

15.

FILED

1927

Nov 17 *Max Starceoff*
 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 *Nov 29*, 19*26*, to *Jan 13*, 19*27*, that I last saw h. *Jan 13* at *5:30* p.m. and that death occurred, on the date stated above, at *City Hospital*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary tuberculosis
2 1/2 yrs. (duration) yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *R. M. Smith*, M. D.

1/13/27 (Address) *City Hospital*

*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

Dexter Ave.

1-19-26

20. UNDERTAKER

Southern

ADDRESS

7315 S. Bldg.

STATEMENT

STATEMENT OF DEBIT

STATEMENT OF DEBIT

M. Henze

STATEMENT

STATEMENT OF DEBIT

STATEMENT

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City St. Louis, Mo.

Registration District No. 791
Primary Registration District No. 1003

File No.....
Registered No. 592
St. Ward)

2. FULL NAME

(a) Residence. No. 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 M 4. COLOR OR RACE W 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)

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

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

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)

15. FILED 19 Mar 6 1927 Man & Star off

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from to 19..... that I last saw him alive on 19..... and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
, 19 (Address)

*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	DATE OF BURIAL <u>1-19-1927</u>
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

WRITE PLAINLY, WITH FADING INK---THIS IS A PERMANENT RECORD

Every item of information should be fully supplied. AGE should be stated. VACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that they be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

RESERVED FOR BINDING

S-3001