

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

Do not use this space.

3243

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No. **846**

Registered No.

St. Ward)

2. FULL NAME

(a) Residence. No. **2811 Duval St.** **13** Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **9** yrs. **0** mos. **0** ds. How long in U.S., if of foreign birth? **40** yrs. **0** mos. **0** ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **11/11/1861**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **65**

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

PARENTS

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT (Address) **City Hospital**

15. FILED **JAN 25 1927** **Marie Starkeoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 23 1927**

17. I HEREBY CERTIFY That I attended deceased from **Jan 22 1927** to **Jan 23 1927** that I last saw him alive on **Jan 23 1927** and that death occurred on the date stated above **Jan 23 1927**

THE CAUSE OF DEATH WAS AS FOLLOWS:
Ulcer of Stomach
8 Hapapery

CONTRIBUTORY (SECONDARY) **7401**

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

DID AN OPERATION PRECEDE DEATH: **No**

WAS THERE AN AUTOPSY: **No**

WHAT TEST CONFIRMED DIAGNOSIS: (Signed) **M.D.** **1/27/27** (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 **St. Mark's Cem. Granite City Ill** DATE OF BURIAL **Jan 26 1927**
20. UNDERTAKER **J. J. Lohely** ADDRESS **Madison Ill**

WRITE IN INK, 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.

Lauren