

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

Do not use this space.

5828

**1. PLACE OF DEATH**

County St. Louis Registration District No. 789 File No. \_\_\_\_\_  
 Township Central Primary Registration District No. 60330 Registered No. 4-6  
 City Pine Lawn, Mo. No. 4419 Willowood Ave. Ward \_\_\_\_\_

**2. FULL NAME**

Arthur A. Lister  
 (a) Residence. No. 4419 Willowood Ave. 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. 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) Married

5A. IF MARRIED, Widowed or Divorced HUSBAND or (last name of) Harriet Lister

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 14 1871

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
55 | 4 | 28 | \_\_\_\_\_

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired  
 (b) General nature of industry, business, or establishment in which employed (or employer) Steam R.R. Conductor  
 (c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know  
 (STATE OR COUNTRY)

14. INFORMANT Harriet Lister  
 (Address) 4419 Willowood Ave

15. FILED 2/14, 1927 P. Lee Bump REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2 **16. DATE OF DEATH (MONTH, DAY AND YEAR)** Feb. 12 1927

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 1927, to \_\_\_\_\_, 1927, that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 1927, and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Cerebral hemorrhage  
7401  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) Meningitis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ 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? Edgewood Hospital  
 (Signed) H. B. Wright, M. D.  
2/13, 1927 (Address) 300 N. Water St. St. Louis

\*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 Calvary Cem. DATE OF BURIAL Feb. 15 1927

20. UNDERTAKER Geo. W. Clark ADDRESS 1125 Hodiaman

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.

MAR 28 1927

DEPARTMENT RECORD

