

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

Do not use this space.

6136

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township.....
 City **St. Louis** (No. **1003** Secondary Registration District No. **1003** Registered No. **1312** Ward)

2. FULL NAME

(a) Residence No. **14** Usual place of abode) St. **15** Ward. (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 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) Unknown		
7. AGE YEARS Ab. 69	MONTHS	DAYS
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) Wales		
10. NAME OF FATHER Unknown		
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) " "		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb. 4 1927**

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy (Cerebral Hemorrhage)

CONTRIBUTORY (SECONDARY) **None**

18. WHERE WAS DISEASE CONSULTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) **R. A. Vitt**, M. D.
 Address **Coronet**

*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.

14. INFORMANT **N. Benson**
 (Address) **4715 McPherson**

15. FILED **FFB** on **7** 1927 by **Starceff**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Waco, Cambria, Mo.** DATE OF BURIAL **FEB - 7 1927**

20. UNDERTAKER **H. P. Berger** ADDRESS **McPherson**

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.

