

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

Do not use this space.

6428

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **City Hospital**)
14449

File No.
Registered No. **1633**
St. Ward)

2. FULL NAME

(a) Residence. No. St. **23** 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** **white** | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb 2 1927**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 1 hrs. or 15 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) **St. Louis**
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER **Joe Kendall**

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

12. MAIDEN NAME OF MOTHER **Lorna Hassel**

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

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

15. FEB 15 1927
FILED **May 6 Starckoff**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from **Feb 2 1927**, to **Feb 2 1927**, that I last saw him **alive** on **3:30** **PM**, and that death occurred, on the date stated above, at **3:30 PM**.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Immaturity
and 5 months
154 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **16101** (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.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **Thos Starckoff**, M. D.
1/3 1927 (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 **POTTERS FIELD.** **DATE OF BURIAL** **2-7-1927**

20. UNDERTAKER **G. Harrison 1426 Canal**
ADDRESS

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.

Massif

11-10-1914

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