LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

6493

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

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 1705

Township ..... Primary Registration District No. 1003 Registered No. .....

City St. Louis (No. 6132 Westminster St. ..... Ward)

2. FULL NAME James W. Samuel

(a) Residence. No. 6132 Westminster, Place 5
(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 OF (OR) WIFE OF: Jennie R. Samuel

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 1, 1878

7. AGE: Years 48 | Months 6 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

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): Coffee Salesman
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): St Louis
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: Edward E. Samuel
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Liberty
(STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Mary Aderton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Arrow Rock
(STATE OR COUNTRY): Mo.

14. INFORMANT: Aderton Samuel
(Address) 5208 Waterman

15. FILED FEB 18 1927, 19..... Max C Starkloff, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb-18 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan-21, 1926, to Feb-18, 1927, that I last saw him alive on Feb-17, 1927, and that death occurred, on the date stated above, at 5:12 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Mouth

43 (duration) yrs. 18 mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Do not Know

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Microscopic

(Signed) Ellis Fischel, M.D.

2/18, 1927 (Address) 400 Metropolitan Bl

*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: Bellefontaine
DATE OF BURIAL: Feb 19 1927

20. UNDERTAKER: Wagoner
ADDRESS: 3621 Olive

WRITE PLAINLY, 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.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... ..... 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	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)

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..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(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?.....

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 19
20. UNDERTAKER	ADDRESS

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