LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

6591

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

1. PLACE OF DEATH

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

Township..... Primary Registration District No. 1003 Registered No. 1816

City..... (No. 4367 Cotebriliant St. ..... Ward)

2. FULL NAME Arsro Sheilds

(a) Residence. No. 4367 Cotbriliant St., 11 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)
male	Col	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1 1880

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	46	11	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Expressman

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Knoxville
(STATE OR COUNTRY) Tennessee

PARENTS

10. NAME OF FATHER Dont Know

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Ogena Sheilds
(Address) 4367 Cotebriliant

15. FILED ..... 19.. May C Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 - 20 - 1927

17. I HEREBY CERTIFY, That I attended deceased from 1 - 2 ....., 1927, to 2/20, 1927 that I last saw him alive on 2 - 20 - 1927, and that death occurred, on the date stated above, at 1.57 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Nephritis (Parenchymatous) due to Chronic Catarrhal Gastritis

Chronic (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Catarrhal Gastritis, Stricture of pylorus & of Stomach due to Chronic Catarrhal Gastritis

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical bed side diagnosis

(Signed) J. L. Walker, M. D

2/21, 1927 (Address) St Louis Mo

*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 Green Wood Cem

DATE OF BURIAL 2 - 23 1927

20. UNDERTAKER Peoples undertaking Co

ADDRESS 3100 Franklin

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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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.

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(a) Trade, profession, or particular kind of work .....

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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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