

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

Do not use this space.

9800

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis, Mo.** (No. **City Hosp. No. 2**)

File No.....
 Registered No. **2112**
 St. Ward)

2. FULL NAME

(a) Residence. No. **James Reese**
 (Usual place of abode) **2845 R. Walnut St., 12 Ward.**

Length of residence in city or town where death occurred **11** 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 **negro** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 28, 1875**

7. AGE YEARS MONTHS DAYS IF LESS than I day, hrs. or min.
51 | 5 | 2.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Wood + Coal Dealer**
 (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) **Mo.**

10. NAME OF FATHER **John Reese**

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

12. MAIDEN NAME OF MOTHER **Mollie Unknown**

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

14. INFORMANT (Address) **Anna J. Woodard City Hospital # 2**

15. FILED **Mar 3 1927** **Mable Starneff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from **Feb. 27, 1927**, to **March 2, 1927** that I last saw him alive on **March 2, 1927**, and that death occurred, on the date stated above, at **1:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy due to
Chronic Nephritis
 (duration) yrs. mos. ds. **3. ds.**
 CONTRIBUTORY (SECONDARY) **Indefinite**

18. WHERE WAS DISEASE CONTRACTED? **At home**

DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____
 WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Chemical + Microscopic**
 (Signed) **J. W. Gray** M. D.
3/2, 1927 (Address) **City Hosp. No. 2**

*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 **Bloomfield N.Y.** DATE OF BURIAL **Mar 3 1927**

20. UNDERTAKER **A. C. Beal** ADDRESS **2786 Louisa**

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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