

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

Do not use this space.

9724

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. City or Town)

File No. ....

Registered No. **2263**

St. .... Ward)

**2. FULL NAME**

(a) Residence No. **2003 Market St.** Ward. **7**

(Usual place of abode)

(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

**Col**

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)

**Feb. 14 - 1894**

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

**33**

**≡**

**28**

8. OCCUPATION OF DECEASED

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

**Labor.**

(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

**Bsn. Hughes.**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

**Mo**

12. MAIDEN NAME OF MOTHER

**Francis, Bryant**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

**Mo.**

14.

INFORMANT (Address)

**Effie Bryant Mc Minn  
2003 Market St.**

15.

FILED

BY

19

**Mar. 6 Starkeoff**

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **3-5-27** 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..... **5 a**..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Gun shot wound of chest**  
**11/13** (duration) yrs. mos. da.  
CONTRIBUTORY (SECONDARY) **Homicide**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

9. DID AN OPERATION PRECEDE DEATH DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **Dr. D. D. Brown** M.D.  
**3/7/27** (Address) **Dr. Brown**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

**Father, Dickson, Ca.**

**3-8-1927**

20. UNDERTAKER

ADDRESS

**G. Scott, 3015 Lawton av.**

X. E.—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.

WHILE PRINTING WITH UNFADING INK—THIS IS A PERMANENT RECORD

