

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

Do not use this space.
16316

1. PLACE OF DEATH

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

File No.....
Registered No. **2908**
St..... Ward.....

2. FULL NAME

(a) Residence. No. **2041 La Cleve St.** **21** Ward.
(Usual place of abode)

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF **not known**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 1, 1876**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
50 | 7 | 20.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **laborer**
(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 **Phelix Lewis**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **not known**

12. MAIDEN NAME OF MOTHER **not known**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **not known**

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

15. FILED **48 25 1927** **Male B. Staroff** REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 21 1927**

I HEREBY CERTIFY, That I attended deceased from **Feb 21**, 19**27** to **March 21**, 19**27** that I last saw him alive on **March 21**, 19**27**, and that death occurred, on the date stated above, at **8 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute military Tuberculosis
32B
(duration) yrs. **2** mos. **21** ds.

CONTRIBUTORY (SECONDARY) **370**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

20. WAS THERE AN AUTOPSY? **no**
WHAT TEST CONFIRMED DIAGNOSIS? **Clinical + laboratory**
(Signed) **J. W. Gray, M.D.**
, 19 (Address) **City Wash. D.C.**

* State the DISEASE CAUSING DEATH, or if 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 DATE OF BURIAL

Washington Park Cem. **3-27-1927**
20. UNDERTAKER ADDRESS **3100**

Peoples and Co. **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.

