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

Do not use this space.

10517

File No. 3429

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City ..... (No. 7009 a Pennsylvania a St. ..... Ward)

2. FULL NAME Manuel Fernandez

(a) Residence. No. 7009 a Pa a 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)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
abt	2	6		

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) Missouri

PARENTS

10. NAME OF FATHER Gumersindo Fernandez

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

12. MAIDEN NAME OF MOTHER Neve Lobo

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

14. INFORMANT Mrs. Fernandez
(Address) 7017 Pa. ave

15. FILED MAR 31 1927, 19 Marie Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 30 1927

17. I HEREBY CERTIFY, That I attended deceased from March 26, 1927, to March 29, 1927 that I last saw b. Pan. alive on March 29, 1927, and that death occurred, on the date stated above, at 5 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Catarrhal Pneumonia
Bronchopneumonia
107A
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) Catarrhal Pneumonia
Bronchopneumonia (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) H. L. Gilbert & Tibe, M. D.
, 19 (Address) 4527 W. Lindell

*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 Mount Hope — DATE OF BURIAL 4-1-1927

20. UNDERTAKER Southern — ADDRESS 7315 S. Broadway

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.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD