

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

✓ Do not use this space.
10557
File No. _____
Registered No. 3179
St. _____ Ward _____

1. PLACE OF DEATH

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

2. FULL NAME

Nelson Vincent Lucas
(a) Residence. No. **317** St. **15** Ward. _____
(Usual place of birth)

Length of residence in city or town where death occurred **40** 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) **widowed**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 22, 1846**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80 11 6

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) **Ga.**

PARENTS

10. NAME OF FATHER **Not known**

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) **Tn.**

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

15. FILED **March 27 1927** REGISTERED **Mark Starckoff**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 28 1927**

17. I HEREBY CERTIFY, That I attended deceased from **March 27 1927** to **March 28 1927**, and that I last saw him alive on **March 28 1927**, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS: **Toxemia (organism unknown) Cause unknown**

Non Diabetic (duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **gangrene Rt. foot arteriosclerosis Indolence** _____

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? **No.**

WHY TEST CONTINUED? **Chinich Substrate**

(Signed) **J. W. Gray, M. D.** _____
, 19 (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 **Greenwood Center** DATE OF BURIAL **Apr 4 1927**

20. UNDERTAKER **Daniet & Walter** ADDRESS **2700 Wash**

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.

