

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

Do not use this space.

13509

**1. PLACE OF DEATH**

County..... Registration District No. 782  
 Township..... Primary Registration District No. 24  
 City St. Louis Mo. (No. 724 Wyoming)

File No.....  
 Registered No. 3043  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Noah M. Cecil  
 (a) Residence No. 724 Wyoming St. 24 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 28-1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
79 4 23

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work U. R. Conductor  
 (b) General nature of industry, business, or establishment in which employed (or employer) Street car  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Kentucky

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Kentucky

14. INFORMANT Noah F. Cecil (Address) 724 Wyoming St.

15. FILED APR 22 1927 19 Max C. Starckoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1927, to 4/21, 1927 that I last saw him \_\_\_\_\_ alive on 4/21, 1927, and that death occurred, on the date stated above, at 8:11 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

131 Chronic Nephritis  
164 (duration) 2 yrs. mos. ds.  
 CONTRIBUTORY Senility (SECONDARY) (duration) \_\_\_\_\_ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. mos. ds.  
 IS NOT AT PLACE OF DEATH. \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH. \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) Charles C. Dresser, M. D.  
4/21, 1927 (Address) 3617 S Grand

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL S. S. Peter + Paul DATE OF BURIAL April 25 1927

20. UNDERTAKER Jegenhair Bros. 5623 W. 12th ADDRESS \_\_\_\_\_

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.

