

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

Do not use this space.

13717

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City *St. Louis, Mo.*

(No. *City Hosp. No. E*)

File No.....

Registered No.....

4065

St.....

Ward)

2. FULL NAME

(a) Residence. No. *2007 Chestnut* St.,

21 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *43* 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

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)

not known

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

abt 43

8. OCCUPATION OF DECEASED

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

Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

[Signature]

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Henry Waneu

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ala.

12. MAIDEN NAME OF MOTHER

Jane Palmer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ala.

PARENTS

14. INFORMANT

(Address)

*Mrs. F. Woodard
City Hospital #2*

15. FILED

APR 29 1921

Maub Starckoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

April 16 1921

17.

I HEREBY CERTIFY, That I ~~certified~~ *certified* deceased from *April 11*, 19*21* to *April 16*, 19*21*. That I last saw *him* alive on *April 16*, 19*21*, and that death occurred, on the date stated above, at..... a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia

CONTRIBUTORY (SECONDARY)

108/101A

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?

WHAT TEST CONFIRMED DIAGNOSIS?

Chicago Laboratory

(Signed).....

, 19 (Address)

*J. W. Gray, M.D.
City Hosp. W. 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

DATE OF BURIAL

Washington U. 4/21 21

20. UNDERTAKER

ADDRESS

W. Richter 3500 Ridger

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.

