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

Do not use this space.

13778

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City St. Louis (No. 1433, North 24th St. ..... St. ..... Ward)

File No. .....

Registered No. 4128

2. FULL NAME Albert D. Mather

(a) Residence. No. 1433 N. 24th St., 25 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	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9 - 1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	77	11	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day 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) New York

PARENTS

10. NAME OF FATHER E. Mather

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Bert Mather
(Address) 4527 Virginia Ave

15. FILED MAY - 1 1927 19..... Max C Starkloff
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 4/23/ 1927, to 4/30/ 1927 that I last saw him alive on 4/29/27, 19....., and that death occurred, on the date stated above, at 12 ½ 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
Apoplexy 131
8 VA
..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis
..... (duration) ? yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 1290
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) N. P. Thompson M.D.
4/30/ 1927 (Address) 3108 Leeds

*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 Calvary
DATE OF BURIAL May 3 1927

20. UNDERTAKER Wacker - Helderle
ADDRESS 2331 So. Bway

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.