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

Do not use this space.

16569

791
1903

File No. 4464
Registered No.

1. PLACE OF DEATH

County
Township
City St. Louis Mo (No. Isolation Hospital St. Ward)
Registration District No.
Primary Registration District No.

2. FULL NAME Upton Gore

(a) Residence. No. 1928 Cass Ave. St., 21 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-2-1925

7. AGE: Years 1 | Months 9 | Days 8 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Nil
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Lawrence Gore
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mabel Schonberger
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kan.
(STATE OR COUNTRY)

14. INFORMANT M. O'Brian
(Address) 5400 Arsenal

15. FILED Nov 12, 1927 Max C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) May-10 1927

17. I HEREBY CERTIFY, That I attended deceased from May-10, 1927, to May-10, 1927 that I last saw him alive on May 10, 1927, and that death occurred, on the date stated above, at 8:50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Streptococcic Sore Throat
Non Diphtheritic
115A
93A (duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (SECONDARY) Myocarditis, Acute
(duration) — yrs. — mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH 1920 Cass
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Sergt H. Fariss, M. D
, 19 (Address) Isolation Hospital

*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 St Matthews Cem. | DATE OF BURIAL May 13, 1927

20. UNDERTAKER Central Fund Co. | ADDRESS 1834 Caso

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

Koenen