

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

Do not use this space.

16734

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No. ....

Registered No. **4674**

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **6458 Wanda** St. **2** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. **5** 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)**

**Married**

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

**Ms Nellie Shoup**

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

**May 28 - 1867**

**7. AGE**

**65** YEARS

**11** MONTHS

**18** DAYS

If LESS than 1 day, hrs or min.

**8. OCCUPATION OF DECEASED**

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

**Salesman**

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

**Subscription Books**

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

**Ohio**

**10. NAME OF FATHER**

**James Shoup**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**Ohio**

**12. MAIDEN NAME OF MOTHER**

**Unknown Namson**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**Scotland**

**14.**

INFORMANT

(Address)

**St. Louis City Hospital**

**15.**

FILED

BY **19**

**1327 Marie Saxeoff** REGISTRAR

**1 MEDICAL CERTIFICATE OF DEATH**

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

**May 16 1927**

**17.**

I HEREBY CERTIFY, That I attended deceased from **April 20, 1927** to **May 16, 1927** that I last saw him **live on May 16, 1927**, and that death occurred, on the date stated above, at **3-2 a.m.**

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

**Pulmonary Tuberculosis**

**23H**

(duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

**31**

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

**8** DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

**5/16** (Signed) **Thos C. Imber**, M. D. (Address) **City 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**

DATE OF BURIAL

**Springfield Ohio**

**5/18 1927**

**20. UNDERTAKER**

ADDRESS

**A Ellis 5th & Delmar**

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.

Shoup.

1871