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

Do not use this space.
16769

1. PLACE OF DEATH

County ..... Registration District No. 791
Township ..... Primary Registration District No. 1003
City St. Louis (No. 2238 a Randolph St., ... Ward)

File No. .....
Registered No. 4710

2. FULL NAME Xavier Declue

(a) Residence. No. 2238 a Randolph St., 22 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	Negro	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 24 1842

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
84	8	22	

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

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

PARENTS

10. NAME OF FATHER Batist La Mont
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Balina Declue
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo

14. INFORMANT Elizabeth Declue
(Address) 2238 a Randolph

15. FILED ..... 19 ..... Mark Starsecoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1927, to May 16, 1927, that I last saw him alive on May 16, 1927, and that death occurred, on the date stated above, at 12 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis, Cerebral Hemorrhage
82 A
97 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE DID DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & symptomatology
(Signed) Max Schwartz, M. D.
..... 19 27 (Address) 3700 Olive St.

*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. Peters — DATE OF BURIAL 5-20 1927

20. UNDERTAKER Gates Und. Co. — ADDRESS 4107 Finney

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