

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No. **16779**
Registered No. **4722**
St. _____ Ward)

2. FULL NAME

(a) Residence. No. **976 N 19** 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 **male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov 28 - 1927**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	2	5	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **None**

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY)

10. NAME OF FATHER **Robert Nestor**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Helma Leighton**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY)

14. INFORMANT **Ch. Roman**
(Address) **City Hospital**

15. FILED **MAY 20 1927** **mar. b. Starosoff**
19. _____ REGISTRY

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 19 1927**

17. I HEREBY CERTIFY That I attended deceased from **May 15 1927** to **May 19 1927** that I last saw him alive on **May 19 1927** and that death occurred, on the date stated above, at **7:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

13311
67 Status Lymphaticus
Psychitis

CONTRIBUTORY (SECONDARY) **131a**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

18 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signature) **Thomas Miller, M.D.**

5/19/27 (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 **Valhalla** DATE OF BURIAL **5-20 1927**

20. UNDERTAKER **Arthur J. Donnelly** ADDRESS **2039 Wash St**

X. 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.

RECORD WITH UNFADING INK—THIS IS A PERMANENT RECORD

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