

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

Do not use this space.

16796

1. PLACE OF DEATH

County.....

Registration District No.....

791

File No.....

Township.....

Primary Registration District No.....

1003

Registered No.....

4739

City *St. Louis*

(No. *2414*)

Goode ave.

St.....

Ward.....

2. FULL NAME

(a) Residence. No. *2414* *Goode ave.* St. *11* 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.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male negro

Single

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

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

Jan. 25, 1927

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ____ hrs. or ____ min.

3

24

8. OCCUPATION OF DECEASED

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

Child

(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

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Alice James

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss.

14.

INFORMANT

(Address)

Melissa A. Buchanan
2414 Goode Ave.

15.

FILED

May 28, 1927
May 6 Starcoff

REGISTERED

MEDICAL CERTIFICATE OF DEATH

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

May 19, 1927

17.

I HEREBY CERTIFY That *hath* deceased from *May 19, 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 *1074*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Broncho-Pneumonia Primary

CONTRIBUTORY (SECONDARY)

1000

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH.....

DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Sam L. Perry

M. D.

(Address) *445-2 Westmorely*

*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

Greenwood

5/20/27

20. UNDERTAKER

ADDRESS

A. Russell Und. Co. Pine St.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

