

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

Do not use this space.

16919

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *St. Louis* (No.) St. Ward)

File No.
Registered No. **4872**

2. FULL NAME

(a) Residence No. *226 W. Garfield* 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 *Male* 4. COLOR OR RACE *Negro* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widower*

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>abt 63</i>	<i>?</i>	<i>?</i>	<i>?</i>	<i>?</i>

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn.*

10. NAME OF FATHER ..

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

12. MAIDEN NAME OF MOTHER ..

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

14. INFORMANT *Sam Jackson* (Address) *425 W. Garfield*

15. FILED *21 1927* *Mar 6 Starkeoff* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 22, 1927*

17. I HEREBY CERTIFY, That I attended deceased from *May 10, 1927*, to *May 22, 1927*, that I last saw *him* alive on *May 22, 1927*, and that death occurred, on the date stated above, at *St. Louis*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis

131 (duration) *5* yrs. mos. da.

CONTRIBUTORY (SECONDARY) *unk* (duration) yrs. mos. da.

18. WHERE AS DISEASE CONTRIBUTED *129 a* IF NOT AT PLACE OF DEATH ..

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF ..

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *J. E. Moore* M. D. *5/23, 1927* (Address) *801 E. 7th*

*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 *Greenwood* DATE OF BURIAL *5-25 1927*

20. UNDERTAKER *Sates Und. Co.* ADDRESS *4107 Finney*

WRITE CLEARLY, 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.

