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 Mo (No. City Hosp. Wr. ..... St. ..... Ward)

File No. 17040

Registered No. 5003

2. FULL NAME Joe Follies

(a) Residence. No. 1624 Papin 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 2 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: negro.

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Not known.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 21, 1840

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
87	3	4	

8. OCCUPATION OF DECEASED

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

(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): So Carolina

PARENTS

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Not known.

12. MAIDEN NAME OF MOTHER: Susie Follies

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

14. INFORMANT: Anna F. Woodard (Address) City Hospital #2

15. FILED MAY 28 1927, 19..... Max C. Starkloff, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 25 1927

17. I HEREBY CERTIFY, That I attended deceased from 5/9/27, 19..., to 5/25/27, 19..., that I last saw him alive on May 25, 1927, and that death occurred, on the date stated above, at 9 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cirrhosis of liver, cause Lues

34 124B 127B (duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Cholecystitis

(duration) Indef. mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 122B1

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

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) J. W. Gray, M.D.

, 19 (Address) City Hosp. Wr.

*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: Washington Park

DATE OF BURIAL: 5/28/27 1927

20. UNDERTAKER: Elmer E. Pettis

ADDRESS: 3311 Pine Blvd.

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.