

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

Do not use this space.

20028

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary-Registering District No. **1003**

City **St. Louis** (No. **City / Precinct**)

File No.

Registered No. **5794**

St. Ward)

2. FULL NAME

(a) Residence. No. **11th St. 6** St. **15** Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred **40** 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 | **White** | **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan 20 - 1856**

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.

72 | **5** | **29** | **0** | **0** | **0**

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) **Home**

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **St. Louis**

10. NAME OF FATHER **Wm. Grace**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **St. Louis**

12. MAIDEN NAME OF MOTHER **Jessie Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **St. Louis**

14. INFORMANT **Cherry**

(Address) **City / Precinct**

15. JUN 23 1921 **Mar C Starvoff**

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from **June 15 1927** to **June 19 1927** that I last saw him **live** on **June 19 1927** and that death occurred, on the date stated above, at **5:40 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis

90 B (duration) **9 30** yrs. **16** mos. **2** ds.

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

18. WHERE WAS DISEASE CONTRACTED

8 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **Edmund R. Shepard, M.D.** (Address) **City / Precinct**

*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 **Calvary Cemetery**

DATE OF BURIAL **June 24 1927**

20. UNDERTAKER **J. H. Gibken & Co. 2842 Insurance**

ADDRESS

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

Base