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

Do not use this space.

20050

1. PLACE OF DEATH

County ..... *Registration District No. 791 File No. 5817

Township ..... Primary Registration District No. 1002 Registered No. 1

City St. Louis Mo (Ward) Ewalt City Hospital St. ..... Ward)

2. FULL NAME John Logan

(a) Residence No. 1547 California Av. 23 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~~ (*write* the word): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 18-1886

7. AGE: Years 41 | Months 1 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Decorator 193
(b) General nature of industry, business, or establishment in which employed (or employer): Western Decorating Co.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Illinois

PARENTS

10. NAME OF FATHER: Thomas M. Logan
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Lillie Bell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Mrs Bessie Logan
(Address) 1547 California Av.

15. FILED JUN 21 1927 19 Mae C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 21 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 11:05 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Electrocution due Contact with Electric Wire (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Accident (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 196

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

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature], M. D.

3/vi, 1927 (Address) Coroner

*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 Crematory | DATE OF BURIAL: June 24 1927

20. UNDERTAKER: E. J. Schnur | ADDRESS: 3125 Lafayette av

WHITE PERMANENT, 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.