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

Do not use this space.

20097

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 20097

Township ..... Primary Registration District No. 1003 Registered No. 5864

City St. Louis Mo. (No. City Hospital # 2 St. ..... Ward)

2. FULL NAME Herman McKee

(a) Residence. No. 2214 Chestnut St., 21 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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 Negro

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 11th 1904

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
23	19	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 21

(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) Miss.

PARENTS

10. NAME OF FATHER Erwan McKee.

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

12. MAIDEN NAME OF MOTHER Viola Phillips

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

14. INFORMANT James Gilmore (Address) 2301 St Charles St

15. FILED JUN 26 1927 Max C Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-22 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 4 45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries

2 M (Internal)

Run over by Wagon (duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED? 1884

IF NOT AT PLACE OF DEATH? .....

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

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Wm Dever ~~M.D.~~

6/24/1927 (Address) Dep 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 Mound Bayou Miss

DATE OF BURIAL June 26th 1927

20. UNDERTAKER A. L. Beal

ADDRESS 2726 Lucas Ave

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.