

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. **791**
Primary Registration District No. **1003**

File No. **20144**
Registered No. **5912**
St. Ward)

2. FULL NAME

(a) Residence. No. *1017* *Dixon* St., *227* Ward.
(Usual place of abode)

(If non-resident 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 *White* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

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

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

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, ___ hrs. ___ min.
Abt. 38

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

9. BIRTHPLACE (CITY OR TOWN) *Washington*
(STATE OR COUNTRY) *D.C.*

PARENTS

10. NAME OF FATHER *Not ascertainable*
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 *H. W. Heath*
(Address) *Bureau Office*

15. FILED *JUN 28 1927* *Man's Star* REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6/24-1927*

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 *9-30* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

gunshot wound of Abdomen
Accident (duration) *18 1/4* yrs. mos. da.
CONTRIBUTORY (SECONDARY) *18 3* (duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? DATE OF.....
WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS? *H. W. Heath M.D.*
6/25 1927 (Address) *Deputy Coroner*

*State the DISEASE CAUSING DEATH, or 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 *Cape More* DATE OF BURIAL *June 29, 1927*

20. UNDERTAKER *A. W. McLaughlin* ADDRESS *1631 Duessan*

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.

DEPARTMENT RECORD

