

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

Do not use this space.

20244

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City, *St. Louis, Mo. (No. City Hosp. No.)*

File No.

Registered No. **6049**

St.

Ward)

2. FULL NAME *Henry Richmond*

(a) Residence. No. *5307 Vernon* St., *5* Ward.

Length of residence in city or town where death occurred *2* yrs. mos. da.

How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

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) *not known*

7. AGE

abt 67

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *mil*

(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) *Mo.*

10. NAME OF FATHER *John Richmond*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *N. Carolina*

12. MAIDEN NAME OF MOTHER *Queen unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *N. Carolina*

PARENTS

14. INFORMANT *Anna F. Woodard*

(Address) *City Hospital #2*

15. FILED *JUN 30 1927*

19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 5 1927*

17.

I HEREBY CERTIFY, That I attended deceased from *April 13* 19*27*, to *June 5* 19*27* that I last saw him alive on *June 5 1927* and that death occurred, on the date stated above, at *4:25 p. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremic Coma

131 / 129 W

(duration) yrs. mos. *15* da.

CONTRIBUTORY (SECONDARY)

*Chronic nephritis
Indefinite*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *No*, DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Chemical Nephrosy*

(Signed) *J. W. Wray*

, 19 (Address) *City Hosp. No. 2*

M. D.

*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

DATE OF BURIAL

Washington

6/9 27

20. UNDERTAKER

ADDRESS

W. Richter

3500 Rutger

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.

STATEMENT RECORD

