

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

Do not use this space.

22896

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *City Hospital*)

File No.

Registered No. **6566**

St. Ward)

2. FULL NAME *Malcolm Segastun*

(a) Residence. No. *2214 Star St.* Sl. *26* Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1 1/2* 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)

abt. Feb. 1899

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ___ hrs. or ___ min.

abt. 28

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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

New York

10. NAME OF FATHER

Alvin Segastun

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tennessee

12. MAIDEN NAME OF MOTHER

Josephine Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

14.

INFORMANT

(Address)

City Hospital

15.

FILED

Jul 19 1927

Marb. Starckoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

July 18 1927

17.

I HEREBY CERTIFY That I attended deceased from *June 8, 1927* to *July 18, 1927* that I last saw him alive on *July 15, 1927* and that death occurred, on the date stated above, at *8 - a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulm. tuberculosis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Edmund R. Sheridan, M. D.*
17/18, 1927 (Address) *City Hospital*

*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

Bellefontaine Cemetery

7-20 1927

20. UNDERTAKER

ADDRESS

J E Mercer

St. Louis City

WRITE PLAINLY, 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.

Segastum