

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

Do not use this space.

23282

1. PLACE OF DEATH

County.....

Registration District No. **781**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **7031**

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

St. Ward)

2. FULL NAME

(a) Residence. No. **3931 Washington** St., **19** Ward.

(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)

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

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

July 18 - 1927

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, **3** hrs. or **---** min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (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)

St. Louis

10. NAME OF FATHER

Lemon Byrd

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis

12. MAIDEN NAME OF MOTHER

Wesley Forrest

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis

14.

INFORMANT

(Address)

Anna ... City Hospital

15.

FILED

19

Marie Starkeoff
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 **July 18 1927** to **July 18 1927** that I last saw him alive on **July 18 1927**, and that death occurred, on the date stated above, at **1:00** p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary Artery 7 months
atherosclerosis
(duration) yrs. mos. ds.
1610
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

/ IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Henry C. Westerman, M.D.**
7/19 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

YVONERS FIELD

8-4-1927

20. UNDERTAKER

ADDRESS

E. Shannon 1424 Cass

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.

PHOTOGRAPH OF DECEASED

Sybil.