

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

Do not use this space.

25471

1. PLACE OF DEATH

County..... Registration District No. **791** File No.
 Township..... Primary Registration District No. **1408** Registered No. **7053**
 City **St. Louis** (No. **Mississippi River foot Chouteau Ave** St. Ward)

2. FULL NAME

(a) Residence. No. **Unknown** St. **22** Ward.
 (Usual place of abode) (If nonresident 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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <i>Unknown</i> <small>(write the word)</small>
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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. or min.
<i>abt</i>	<i>40</i>	<i>-</i>	<i>-</i>	<i>-</i>

8. OCCUPATION OF DECEASED

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

PARENTS	10. NAME OF FATHER	<i>-</i>	<i>-</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)	<i>-</i>	<i>-</i>
	12. MAIDEN NAME OF MOTHER	<i>-</i>	<i>-</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)	<i>-</i>	<i>-</i>

14. INFORMANT (Address) *H.W. Faith, Registrar's Office*

15. FILED *AUG - 4 1927* *Mauro Stankoff* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8/1 1927*

17. I HEREBY CERTIFY, That I attended deceased from
 , 19....., to 19....., and that death occurred, on the date stated above, at *12-00* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Drowning
Whether accidental or intentional not ascertainable
183 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *182* (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *182*
 IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH. DATE OF.....
 WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS. *H.W. Faith* (Signed)
8/4 1927 (Address) *Registrar's Office*

*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 *Roller Field* **DATE OF BURIAL** *8-4 1927*

20. UNDERTAKER *Southern N-L Co* **ADDRESS** *365 S. Broadway*

N. B.—Every item of information should be carefully supplied. AGB 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

