

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

Do not use this space.

25754

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1093**
 City **St. Louis, Mo.** (No. **4479^e Forest Park Blvd**) St. **18** Ward **18**
 Registered No. **7355**

2. FULL NAME

(a) Residence, No. **4479^e Forest Park** St., **18** 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. 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) **Widowed**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 16 - 1843**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 | **11** | **28**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Retired**
 (b) General nature of industry, business, or establishment in which employed (or employer) **Farmer**
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mo**

10. NAME OF FATHER **Milton Jacks**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER **Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

14. INFORMANT **Miss Mary Kelly**
 (Address) **4479^e Forest Park Blvd**

15. FILED **AUG 15 1927** **Max G. Starrett**
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug 14 1927**

17. I HEREBY CERTIFY, That I attended deceased from **July 27th**, 19**27**, to **Aug 14**, 19**27**, that I last saw him alive on **Aug 14th**, 19**27**, and that death occurred, on the date stated above, at **3:50 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
16^{yr} (duration) yrs. mos. ds.
 CONTRIBUTORY **Senile debility**
 (SECONDARY) (duration) 1 yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? **usual**
 (Signed) **Dr. H. Sponner**, M. D.

8/15, 19**27** (Address) **4397 Forest Park Blvd**

*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 **Valhalla** DATE OF BURIAL **Aug 16 1927**

20. UNDERTAKER **Amberst Ind Co** ADDRESS **234 W. Chestnut**

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.

THIS IS A PERMANENT RECORD

