

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

Do not use this space. ✓

25895

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... File No.
 City..... *St. Louis* (No. *City Hospital #2*) Primary Registration District No. **1003** Registered No. **7509**
 St. Ward)

2. FULL NAME

(a) Residence. No. *2605 Lawton St.* H. Ward.
 (Usual place of abode)
 Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.
 (If non-resident 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) *Widowed*

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. 60</i>	<i>?</i>	<i>?</i>	<i>?</i>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Nil*
 (b) General nature of industry, business, or establishment in which employed (or employer) *Labor*
 (c) Name of employer

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

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Adeline*

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

14. INFORMANT (Address) *Anna F. Woodard City Hospital #2*

15. FILED *AUG 22 1927* *Man. V. Starkey* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug. 15, 1927*

17. I HEREBY CERTIFY That I attended deceased from *8/12* 1927, to *8/15* 1927, that I last saw him alive on *8/15* 1927, and that death occurred, on the date stated above, at *6:25 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of Mandible.
450 (duration) yrs. *8* mos. ds.
 CONTRIBUTORY (SECONDARY) *45* (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF

20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Physiological*
 (Signed) *J. J. Thomas* M. D.
 Address *City Hospital #2*

*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 *Brunswick* DATE OF BURIAL *Aug 22 1927*

20. UNDERTAKER *Demet. J. Walton* ADDRESS *2701 Wash St*

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

