

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

Do not use this space.

26004

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis* (No. *925*, *Maryville Ave* St. *5* Ward) Registered No. *17627*

2. FULL NAME *Percy Alexander*

(a) Residence. No. *925 Maryville Ave* St. *5* Ward. (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. ds.

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 *Edmunda Buse*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 20 - 1874*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
53 3 6

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

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

10. NAME OF FATHER *Archibald Alexander*

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

12. MAIDEN NAME OF MOTHER *Anna Behrens*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *St. Charles Mo*

14. INFORMANT *Archibald Alexander* (Address) *925 Maryville Ave*

15. FILED *AUG 27 1927* *maile Starscoff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 24* 19 *27*

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... *2:30 a.m.*

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
 921. (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) *W. H. M. A.* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRATED IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEED DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *P. J. Vitt* M. D.
8/29, 1927 (Address) *Coroner*

*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 *St. Charles Mo* DATE OF BURIAL *Aug 29 1927*

20. UNDERTAKER *Dallmeyer* ADDRESS *St. Charles Mo.*

COPY, 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.

