

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

Do not use this space.

26166

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
Name *Enroute to Hosp*

File No.....
Registered No. *7830*
St. Ward)

2. FULL NAME

Traveltime Miles
(a) Residence No. *2229 A Franklin St.*
(Usual place of abode)

W 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. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Negro* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *single*
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 25 - 1908*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>18</i>		<i>10</i>	<i>3</i>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *Atkins*
(STATE OR COUNTRY) *Ark*

PARENTS

10. NAME OF FATHER *Robert Miles*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Little Rock*
(STATE OR COUNTRY) *Ark*

12. MAIDEN NAME OF MOTHER *Milena Strakes*

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

14. INFORMANT *Emma Bunting*
(Address) *2713 1/2 Standard St.*

15. FILED *-2 1927* *Marb Starckoff*
19. REGISTRY

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8-28 1927*

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Sun shot wound of chest
1915

CONTRIBUTORY (SECONDARY)

Home

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Wm Dever* M.D.
8/30/27 (Address) *Dep Governor*

*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

Atkins Ark

DATE OF BURIAL

9-2 1927

20. UNDERTAKER

C. J. Yates

ADDRESS

4107 Finney

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.

