

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

Do not use this space.

28386

1. PLACE OF DEATH

County.....

Registration District No. 791

File No.

Township.....

Primary Registration District No. 1903

Registered No. 7906

City St Louis mo (No. Rear 6912 S Parkway)

St. Ward)

2. FULL NAME

M L Kendrick

(a) Residence. No. 4038 Fairfax St. 11 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 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

Col

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF Lillear Kendrick
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

10/13/1889

7. AGE

YEARS 37

MONTHS 11

DAYS 18

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Labourer 1950

(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)

Not Known

10. NAME OF FATHER

Anderson Kendrick

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Not Known

12. MAIDEN NAME OF MOTHER

Katie Tucker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Not Known

14.

INFORMANT
(Address)

Lillear Kendrick
4038 Fairfax ave

15.

FILED

SEP - 6 1927 Man C. Staroboff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-1-27 19

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..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries
Fractured skull
Struck & knocked against
R.R. frame (duration) while in fight

CONTRIBUTORY

formed
with fist. (duration) mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

9/2/27 (Signed) Wm Dever M.D.
(Address) Dep 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

DATE OF BURIAL

Washington Park Cemetery 9/6 1927

20. UNDERTAKER

ADDRESS

Dunn Bros 215 S Jefferson

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.

