

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

Do not use this space.

28808

**1. PLACE OF DEATH**

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City Louis (No. 7469)

City Hospital

791  
1003

File No.....

Registered No. 8354

St. .... Ward.....

**2. FULL NAME**

(a) Residence. No. Not Home St. 23 Ward.....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 11 - 1883

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
44 3 3

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work waiter  
(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) Michigan

10. NAME OF FATHER Wideman

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

12. MAIDEN NAME OF MOTHER ✓ ✓

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

14. INFORMANT Dr. Ross  
(Address) City Hospital

15. FILED SEP 20 1922 Max C. Starker  
19..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

I HEREBY CERTIFY That I attended deceased from Sept 6, 1927, to Sept 14, 1927 that I last saw him alive on Sept 14 1927 and that death occurred, on the date stated above, at 8:20 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic pulmonary tuberculosis  
23 A

CONTRIBUTORY (SECONDARY) 31  
(duration)..... yrs. mos. da.

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

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

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) Edmund R. Sheldon, M.D.  
9/14, 1927 (Address) City Hospital

\*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 Conway Arts DATE OF BURIAL 9-21 1927

20. UNDERTAKER Southern U. & L. ADDRESS 7315 S. Broadway

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.

RECORD

Griffin

21 27.00  
13.70

1110 1.19.23