

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

Do not use this space.

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... *St. Louis* City Registration District No. **1003** File No. **28814**  
 City..... *St. Louis* (Name of City, Hospital, #) **City Hospital #2** Registered No. **8360**  
 St. .... Ward.....

**2. FULL NAME**

(a) Residence No. **2703 77-14th** St., **25** Ward.  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred **24** 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 **Negro** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 25, 1872**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.  
**27 3 17**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **Laborer**  
 (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) **N.Y.**

10. NAME OF FATHER **George Sisk**

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

12. MAIDEN NAME OF MOTHER **May Todd**

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

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

15. FILED **20** 19**27** **Mar C. Stanley** REGISTRAR

**1 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 12, 1927**

17. I HEREBY CERTIFY That I attended deceased from **9/11**, 19**27**, to **9/12**, 19**27** that I last saw him, alive on **9/12**, 19**27**, and that death occurred on the date stated above, at **11:20 a.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Chronic myocarditis**  
**936**

**indefinite** (duration)..... yrs. .... mos. .... da.

CONTRIBUTORY (SECONDARY) **936** (duration)..... yrs. .... mos. .... da.

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

0 DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical & lab**  
 (Signed) **W. B. Howell**, M. D.  
 , 19 (Address) **City Hosp. #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 **Butter Field** DATE OF BURIAL **9/21 1927**

20. UNDERTAKER **Summ Bros** ADDRESS **215 S. Jefferson Ave**

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.

