

**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..... Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)..... St. Ward)

File No. **29101**
Registered No. **8590**

2. FULL NAME

(a) Residence. No. **1406 N Taylor St.** **12** Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. **6** 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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Apr 19 1927**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
7 | **10** |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **119B**
(b) General nature of industry, business, or establishment in which employed (or employer) **107A**
(c) Name of employer

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

10. NAME OF FATHER **Island Miller**

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

12. MAIDEN NAME OF MOTHER **Emelyn Keller**

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

14. INFORMANT **E. Roman**
(Address) **City Hospital**

15. FILED **30 1927** **Max B. Starckoff**
19. RECORDED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 29 1927**

17. I HEREBY CERTIFY That I attended deceased from **Sept 9**, 19**27** to **Sept 29**, 19**27** that I last saw him alive on **Sept 29**, 19**27** and that death occurred, on the date stated above, at **1:00** **am**.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

**Acute enteritis
Typhoid**
(duration) yrs. mos. da.

CONTRIBUTORY **Broncho-pneumonia**
(SECONDARY)

Secondary (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **119B**

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH **8** DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Edmund R. Speridan, M.D.**
9/29, 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 **C. St. Louis Ill.** **9-30-1927**
DATE OF BURIAL

20. UNDERTAKER **Dagon Kassy, C. St. Louis Ill.**
ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important.

RECORD

Miller