

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

Do not use this space.

31600

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

File No.

Registered No. **8936**

St. Ward)

2. FULL NAME

(a) Residence. No. **1319 D 8** St. **12** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **2** 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** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 28 - 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
28 | 1 | 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Latimer 9972**
(b) General nature of industry, business, or establishment in which employed (or employer) **day 970**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Old Mines Missouri

10. NAME OF FATHER John Requette

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

12. MAIDEN NAME OF MOTHER Sarah Polatty

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

14. INFORMANT (Address) **OR** **City Hospital**

15. FILED **11-7 1927** **Maule Starckoff** Registrar

26 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 6 1927

17. I HEREBY CERTIFY That I attended deceased from **Sept 26 1927** to **Oct 6 1927** that I last saw h. k. f. alive on **Oct 6 1927**, and that death occurred, on the date stated above, at **1:27 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebro-spinal meningitis (streptococic)

CONTRIBUTORY Abscess frontal region (SECONDARY) (streptococic) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **W**

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY Yes.

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **Edmund R. Shepdon, M.D.** 10/6/27 (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 **DATE OF BURIAL**
Potosi Mo **1910 27**

20. UNDERTAKER **ADDRESS**
J.B. Boyer **Potosi Mo**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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