

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

Do not use this space.

31610

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City..... St. Louis (No. City Hospital #1) St. Ward)

File No.....
 Registered No. 8950

2. FULL NAME

(a) Residence. No. St. 23 Ward. Kansas City Mo.
 (Usual place of abode) (If nonresident give city of town and State)
 Length of residence in city or town where death occurred 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) unknown

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
abt 60 | |

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Laboren 186A 194B
 (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) unknown

10. NAME OF FATHER

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)

14. INFORMANT (Address) Tom Dever Coroners Office

15. FILED 519 1227 ma & Barcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-2 1927

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... 2-10-2 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Stroke & injuries
Fracture skull
Fall to pavement
 (duration)..... yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Accident
 (duration)..... yrs. mos. ds.

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

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

WHAT TEST COMPLETED DIAGNOSIS.....
 (Signed) Tom Dever M.D.
10/7, 1927 (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 St Trinity Lutheran DATE OF BURIAL 10/7 1927

20. UNDERTAKER Southern U & L Co ADDRESS 7315 S. Bidway

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.

