

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

Do not use this space.

31677

**1. PLACE OF DEATH**

County..... Registration District No. **791**

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

City **St. Louis** (No. **4569 N. Pine**)..... St. .... (Ward)

File No. ....

Registered No. **9019**

**2. FULL NAME** **Redmond Stephen Golson**

(a) Residence. No. .... St. **19** Ward. ....  
(Usual place of abode) (If nonresident give city or 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** **Married**

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** **Katharene Truin Golson**

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** **June 29<sup>th</sup> 1862**

**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
**65** **3** **10**

**8. OCCUPATION OF DECEASED**  
(a) Trade, profession, or particular kind of work **General Contractor**  
(b) General nature of industry, business, or establishment in which employed (or employer) **131**  
(c) Name of employer **19**

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** **New York**

**10. NAME OF FATHER** **John E. Golson**

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

**12. MAIDEN NAME OF MOTHER** **Emerson**

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

**14. INFORMANT** **Mrs. Katharene Golson**  
(Address) **4569 N. Pine St**

**15. FILED** **OCT 10 1927** **May C. Starceoff**  
19. ....  
REGISTERED

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** **10-9 1927**

**17. I HEREBY CERTIFY**, That I attended deceased from **Sept 12<sup>th</sup> 1927** to **Oct 9<sup>th</sup> 1927** that I last saw h. alive on **Oct 9<sup>th</sup> 1927**, and that death occurred, on the date stated above, at **4 P** m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
**Uræmia consequent on Chronic Septic nephritis**

**CONTRIBUTORY (SECONDARY)** **Arterial Hypertension, Angina pectoris & Chronic Myocarditis**  
(duration) yrs. mos. ds. (duration) yrs. mos. ds.

**18. WHEREAS DISEASE CONTRACTED** **131**  
IF NOT AT PLACE OF DEATH? **no**  
DID AN OPERATION PRECEDE DEATH? **no** DATE OF .....

WAS THERE AN AUTOPSY? **no**  
WHAT TEST CONFIRMED DIAGNOSIS? **clinical**  
(Signed) **Edward S. Smith, M. D.**

**Oct 10<sup>th</sup> 1927** (Address) **3720 Wash St**

\*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** **Calvary** **DATE OF BURIAL** **10/11 1927**

**20. UNDERTAKER** **Arthur J. Donnelly** **ADDRESS** **2039 Wash St**

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.

Mr Edmund Smith

3720 Washington

Jeff 5440