

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

Do not use this space.

31689

1. PLACE OF DEATH

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

File No. _____
 Registered No. **9031**

2. FULL NAME

Arnold Alvarez
 (a) Residence. No. *627 Harris* St. *9* 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 (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 30-1919*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
7 | 10 | 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *At School*
 (b) General nature of industry, business, or establishment in which employed (or employer) *67*
 (c) Name of employer _____

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

10. NAME OF FATHER *Manuel Alvarez*

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

12. MAIDEN NAME OF MOTHER *Mauda Suarez*

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

14. INFORMANT *Manuel Alvarez*
 (Address) *627 Harris*

15. FILED *OCT 11 1927* *may 6 started off*

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, death occurred, on the date stated above, at _____, 10:25 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Stomach - Thymico - Symplicatus
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *W.M.D.*
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *67*
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? *R. J. Witt*
 (Signed) _____, M. D.
 + 27 Address *Combes*

*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 *6/2 1927*

20. UNDERTAKER *W. H. Wood* ADDRESS *2117 E. Grand*

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.

