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

Do not use this space. 38366

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 11031

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

2. FULL NAME Infant Thias

(a) Residence. No. 2233 Park av. St. 22 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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): Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 9 - 27

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(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) St Louis

PARENTS

10. NAME OF FATHER: Charles Thias
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St Louis
12. MAIDEN NAME OF MOTHER: Lory McDougal
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mississippi

14. INFORMANT: Chas. Thias
(Address) 2233 Park av.

15. FILED DEC 10, 1927 Max C Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 11 30 p.m. 12/8, 1927, to 9 30 a.m. 12/9, 1927 that I last saw b. ..... alive on 12/9, 1927, and that death occurred, on the date stated above, at 9 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

~~Cause~~ Acute gastro enteritis
Umbilical Hernia
122A (duration) ..... yrs. ..... mos. 10 hours ds.
119B
CONTRIBUTORY (SECONDARY) 113B (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Jos. P. Berman, M. D.
12/9, 1927 (Address) 1504 No. 16 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: St Peter Cemetary
DATE OF BURIAL: 12-10 1927

20. UNDERTAKER: Spelbrink Und. Co
ADDRESS: 1321 Franklin

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.