

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

Do not use this space.

38458

1. PLACE OF DEATH

County..... Registration District No. **701**

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

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

File No.

Registered No. **11131**

St. Ward)

2. FULL NAME

(a) Residence. No. **4924 Massachusetts** 10 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. **2** 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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept 26 1927**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **2 16**

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (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) **Missouri**

10. NAME OF FATHER **John McCullough**

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

12. MAIDEN NAME OF MOTHER **Cloris Beck**

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

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

15. FILED **DEC 13 1927** **Man C. Starkeoff**

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec 12 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Dec 3**, 19**27**, to **Dec 12**, 19**27**, and that I last saw him **live** on **Dec 12**, 19**27**, and that death occurred, on the date stated above, at **1:30 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Congenital deformity of genital and rectal tracts. Acute gastro-enteritis. Acute Hemorrhage.

CONTRIBUTORY (SECONDARY) **1131** **1573**

18. WHERE WAS DISEASE CONTRACTED **1131** **1573**

DID AN OPERATION PRECEDE DEATH? DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? **12/12/27** (Signed) **Edmund R. Sheridan M.D.** (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 **Oakland** DATE OF BURIAL **12/13 1927**

20. UNDERTAKER **Arthur Kelly** ADDRESS **4524 Easton**

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.

WHILE PRINTING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

McLough