

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

Do not use this space.

38543

1. PLACE OF DEATH

County.....
Towship.....
City..... (No.)

Registration District No. **791**
Primary Registration District No. **1003**

File No.
Registered No. **14223**
St. Ward)

2. FULL NAME

Walter Huston
(a) Residence. No. **3525 Lawton ave.** St. **21** 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *col* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

6A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF *Mrs. Mary Huston*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 24 - 1891*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
35 11 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *R.R. Laborer*
(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) *Miss*

10. NAME OF FATHER *Walter Huston*

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

12. MAIDEN NAME OF MOTHER *Cornelius Hawkins*

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

14. INFORMANT *Mrs. Mary Huston*
(Address) *3525 Lawton*

15. FILED *DEC 16 1927* *Mar. C. Starckoff*
19. Registrar

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 13 19*
17.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain Myocarditis
131 93C
Heart Failure, mitral regurgitation
(SECONDARY)
Mur (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
8. DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? *Yes*
WHAT TEST CONFIRMED THE DIAGNOSIS?
131 (Signed) *Dr. V. C. ...* M. D.
12 (Address) *...*

*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 *Washington Park Cem.* DATE OF BURIAL *Dec 17 1927*
20. UNDERTAKER *Watson and Son* ADDRESS *2541 Chouteau Ave.*

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.

