

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

Do not use this space.

38654

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis City Hospital #2 St. Ward.....

File No.....
 Registered No. 11355
 St. Ward.....

2. FULL NAME

(a) Residence. No. 1136 1/2 14th St., 22 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. 3 mos. 17 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Col. 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) Aug 24 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. or ... min.
3 7 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work nil
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Roosevelt Roonce

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

12. MAIDEN NAME OF MOTHER Viola Lewis

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

14. INFORMANT Anna F. Woodard
 (Address) City Hospital #2

15. FILED DEC 19 1927 man 6 Starceff
 19. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 11, 1927

17. I HEREBY CERTIFY, That I attended deceased from 9/28, 1927, to 12/11, 1927, that I last saw him alive on 12/11, 1927, and that death occurred, on the date stated above, at 19:55h m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia
Secondary 1924
acute (duration) yrs. mos. ds.
Pneumonia

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Not known
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Aluminum
 (Signed) W. H. Howell, M. D.
 , 19 (Address) City Hosp. #2

*State the DISEASE CAUSING DEATH, or if 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 F. T. BERS FIELD. DATE OF BURIAL 12-26-1927

20. UNDERTAKER R. Astor 2942 Shawton ADDRESS

K. 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.

