

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

Do not use this space.

38702

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis, Mo.

No. 430 N 15th

File No.

Registered No. 11407

St. Ward)

2. FULL NAME

Joseph Hinkle

(a) Residence No. 416 E. 15th St., 25 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male

Col.

Single

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

single

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

not known

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

about 53

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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

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)

St. Louis, Mo.

10. NAME OF FATHER

Not known

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

not known

12. MAIDEN NAME OF MOTHER

Mary Strickland

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

Mo.

14.

INFORMANT (Address)

Charlie Davis 5403 Brown Ave

15.

FILED

DEC 21 1927

Max B. Starckoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-19-27 19

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to

that I last saw him..... alive on....., 19....., and that

death occurred, on the date stated above, at..... a..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
131
936

..... (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Ch. Paralysis

..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

.....

..... WAS THERE AN AUTOPSY.....

..... WHAT TEST CONFIRMED DIAGNOSIS.....

..... (Signed) Wm. Dever, M.D.

..... (Address) Dep. Coroner

*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

Father Dickson Cemetery

DATE OF BURIAL

12/22, 1927

20. UNDERTAKER

Dunn Bros.

ADDRESS

215, D. Jeff. 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.

