

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

Do not use this space.

38895

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City, *St. Louis* (No. *1719* S. 7<sup>th</sup> St.)

File No. ....

Registered No. **11636**

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. *1919* St. *23* Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* 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)**

*Married*

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

*Jewell Tibbs*

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

*July 14<sup>th</sup> 1906*

**7. AGE**

YEARS	MONTHS	DAYS	If LESS than 1 day, <u>    </u> hrs. or <u>    </u> min.
<i>21</i>	<i>5</i>	<i>10</i>	

**8. OCCUPATION OF DECEASED**

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

*Day 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)

*Kansas City Mo*

**10. NAME OF FATHER**

*Louis F Tibbs*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Tennessee*

**12. MAIDEN NAME OF MOTHER**

*Lulu Calcutt*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

*Kansas*

**14.**

**INFORMANT**

(Address)

*Lulu Calcutt  
1917 S 7<sup>th</sup> St*

**15.**

FILED

*DEC 27 1927*

*Max C Starkhoff*

RECEIVED

**MEDICAL CERTIFICATE OF DEATH**

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

*12-24 1927*

**17.**

I HEREBY CERTIFY, That I attended deceased from .....

....., 19....., to ..... 19....., and that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at *11:30 a. m.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Asphyxiation*

*Fuel Gas Poisoning*

*11/24/27 Suicide*

**CONTRIBUTORY (SECONDARY)**

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

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

**18 DID AN OPERATION PRECEDE DEATH?**

DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *C. J. Pitt M.D.*, M. D.

(Address) *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**

**DATE OF BURIAL**

*Missouri Crematory*

*12-28 1927*

**20. UNDERTAKER**

**ADDRESS**

*Kiephauer & Co. Manufacturers*

*4104*

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.

