

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

Do not use this space.

3059

**1. PLACE OF DEATH**

County.....

Registration District No. 791

File No. ....

Township.....

Primary Registration District No. 1003

Registered No. 672

City St. Louis (No. 14277)

(No. City 1003) St. Ward

**2. FULL NAME**

(a) Residence. No. 576 Franklin Ward.  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 2 da. How long in U.S., if of foreign birth? yrs. mos. da.

**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) Dec 20 - 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
2 7

**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) St. Louis  
(STATE OR COUNTRY)

10. NAME OF FATHER Carroll Jantzen

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

12. MAIDEN NAME OF MOTHER Grace Rowe

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

14. INFORMANT (Address) City 1003

15. FILED 18 1928 Max S. Starckoff  
19. \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 17 1928

I HEREBY CERTIFY, That I attended deceased from June 17 1928 to June 17 1928 that I last saw him alive on June 17 1928, and that death occurred, on the date stated above, at 8:20 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pneumonia  
107 H (duration) yrs. mos. da.

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

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

DID AN OPERATION PRECEDE DEATH..... DATE OF..... WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS (Signed) Henry C. Mateman M. D. City 1003 1928 (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 Bonne Terre Mo. DATE OF BURIAL 1-19 1928

20. UNDERTAKER Dr. Schumacher ADDRESS 3013

WRITE PENNLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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The following information was obtained from the records of the  
Department of the Interior, Bureau of Land Management, on  
the subject of the above-captioned tract.

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The following information was obtained from the records of the  
Department of the Interior, Bureau of Land Management, on  
the subject of the above-captioned tract.

*Handwritten signature*

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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County..... Registration District No. 791 File No. ....  
 Township St. Louis Primary Registration District No. 1003 Registered No. 6720  
 City St. Louis (No. ....) St. .... Ward .....

**2. FULL NAME** Charles Jinkerson

(a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 7 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M. 4. COLOR OR RACE W. 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) Oct 20 - 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
2 28

**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)

**10. NAME OF FATHER**

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

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

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

(STATE OR COUNTRY)

**14.**

INFORMANT (Address)

**15.**

FILED MAY - 9 1928 mau b starkeoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 17 1928

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Brother's Pneumonia  
Primary  
 (duration) ..... yrs. .... mos. .... da.  
 CONTRIBUTORY (SECONDARY) 1000  
 (duration) ..... yrs. .... mos. .... da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) Henry C. Westerman, M.D.  
 , 19 (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**

**DATE OF BURIAL**

19

**20. UNDERTAKER**

**ADDRESS**

WITH UNFADING

should be carefully supplied in plain terms, so that it may be properly filled out.

MS. 58-1 state N very important.

RE COM. FEE AS PRESCRIBED BY LAW. PARENTS SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNLESS THEY HAVE PAID THE FEE.

SUPPLEMENTARY

S-3059