

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

1. PLACE OF DEATH

County FayetteRegistration District No. 466File No. 5485Township CityPrimary Registration District No. 5677, CRegistered No. 6City St. Louis(No. St. Ward)

2. FULL NAME

Charles James(a) Residence. No. St. Ward. St. Louis
(Usual place of abode)

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

White

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)

Oct 4 1895

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.3347

8. OCCUPATION OF DECEASED

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

Tanner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Fortge

(STATE OR COUNTRY)

Mo

10. NAME OF FATHER

Thomas James

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Virginia

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Mary Pearson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Iowa

(STATE OR COUNTRY)

14.

INFORMANT James James
(Address) St. Louis

15.

FILE

Feb 11, 1928F. W. Pearson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 10 19 28

17.

I HEREBY CERTIFY, That I attended deceased from

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:

Drowning (accidental)85 18 2

(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

Epilepsy

(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) J. P. CapeAddress CoronaFeb 11, 1928

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state

(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Graven Cemetery2/12 19 28

20. UNDERTAKER

ADDRESS

Ed RowlandLawden

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.

MAR 19 1928

22-4-6

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH
County..... Registration District No. File No.....
Township..... Primary Registration District No. Registered No.
City..... (No.) St. Ward.....

2. FULL NAME.....
(a) Residence, No. St. Ward.....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. (If nonresident give city or town and State)
da. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (enter the word)

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

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

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

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employee)
(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..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. ds.

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. ds.

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

WRITE STENOGRAPHICALLY IN 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.

