

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

Do not use this space.

8874

1. PLACE OF DEATH

County Jackson
 Township Law
 City St. Louis (No. 2404 Mercer)

Registration District No. 1002
 Primary Registration District No. 4 Mercer

File No. _____
 Registered No. 1041
 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 2404 Mercer St. Ward _____
 (Usual place of abode)

(If nonresident give city or town and State)

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 4, 1867

7. AGE YEARS 67 MONTHS 5 DAYS 2 If LESS than 1 day, ____ hrs. or ____ min.

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) Mexico

10. NAME OF FATHER Carmita Quiñones

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

12. MAIDEN NAME OF MOTHER Felipez Ramos

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

14. INFORMANT Mrs. Quiñones
 (Address) 2404 Mercer

15. FILED 3/7/28 M. M. Crowe
 19____ asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 6 1928

17. I HEREBY CERTIFY, That I attended deceased from Mar 4, 1928 to Mar 6, 1928 that I last saw him alive on Mar 5, 1928, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
12/21

CONTRIBUTORY Chronic Pancreatic (duration) yrs. ____ mos. ____ da.
Nephritis (duration) yrs. ____ mos. ____ da.

18. WHERE WAS DISEASE CONTRACTED 129 W
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) [Signature] M. D.
 (Address) 2590 Park

*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 St Mary's **DATE OF BURIAL** Mar 7 1928

20. UNDERTAKER Katherine Lemerall
ADDRESS _____

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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