

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

Do not use this space.

10745

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis**

(No. **City Hospital**)

File No.....

Registered No. **2563**

St. Ward)

2. FULL NAME

(a) Residence. No. **3836 Elm** St. **15** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **36** 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

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

June 14 1891

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
36	8	20.	

8. OCCUPATION OF DECEASED

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

Mechanic

(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)

Meris

10. NAME OF FATHER

James Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Meris

12. MAIDEN NAME OF MOTHER

Marie Staehlin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis

14. INFORMANT

(Address)

**Dr. H. M. ...
City Hospital**

15.

FILED **7 1928**

May 6 8 years old

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

March 5 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1927 to March 5, 1928 that I last saw him alive on March 5, 1928, and that death occurred, on the date stated above, at 12:40 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

CONTRIBUTORY (SECONDARY)

Fabo - Paresis Paralysis of the Insane

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?

3/5 (Signed) Henry C. Westerman, M. D. 1928 (Address) City Hospital

*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

Valhalla -

DATE OF BURIAL

3/8/28

20. UNDERTAKER

Stroot Carroll and Co 44 Bridge Ave

WRITE PLAINLY, 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.

Immin