

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

Do not use this space.

10933

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. **2757**

St. Ward)

2. FULL NAME

(a) Residence. No. **1400 R N 14** St., **25** Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 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

Colored

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)

Not known

7. AGE

YEARS MONTHS DAYS

If LESS than 1 day, hrs. or min.

abt. 52

Unknown

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)

St. Louis

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

ll ll

12. MAIDEN NAME OF MOTHER

ll ll

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

ll ll

14.

INFORMANT (Address)

**Edna Mae Neal
1400 R N 14 St**

15.

FILED

12 1928

Mable Starkey

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **3-6-1928**

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

**Stroke & injured (fracture skull)
Struck by Blast**

CONTRIBUTORY (SECONDARY) **Instrument**
175 B (duration) yrs. mos. da

18. WHERE WAS DISEASE CONTRACTED
Homicide

19. DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **3/7/28**
WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **Tom Over** M.D.
3/7/28 (Address) **Dep 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 **WASHINGTON Park** **DATE OF BURIAL** **3-13-1928**

20. UNDERTAKER **W S Wade & Sons** **ADDRESS** **4202 Finney**

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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