

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

Do not use this space.

15745 ⁶/_F
File No. _____
Registered No. 4714
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**

Township _____ Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital # 2**)

2. FULL NAME

(a) Residence No. **4237 St. Ferdinand** Ward **11**
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **10** 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

Negro

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

Widow

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

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

3-31-1902

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
26	0	27	

8. OCCUPATION OF DECEASED

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

Nil.

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

Chauffeur

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Illinois

10. NAME OF FATHER

Giles Cox

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

MO.

12. MAIDEN NAME OF MOTHER

Sarah Thomas

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14. INFORMANT

(Address)

**Anna F. Ward
City Hospital #2**

15. FILED

19 **1928**

Max C. Ward

REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 28 1928**

17. I HEREBY CERTIFY That I attended deceased from **April 19 1928** to **April 28 1928** (that I last saw him... alive on **April 28 1928**, and that death occurred, on the date stated above, at **6:30 P.M.**

THE CAUSE OF DEATH WAS AS FOLLOWS:

Gangrene of Lung's
of 13 da. (duration) yrs. mos. 13 da.
of 13 da. (duration) yrs. mos. 13 da.
CONTRIBUTORY OF Pulmonary Pneumonia and Pulmonary Abscess Indefinite da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH...

19. DID AN OPERATION PRECEDE DEATH No. DATE OF _____

WAS THERE AN AUTOPSY? **NO**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical Laboratory**

(Signed) **Thomas** M.D.

4/30/1928 (Address) **City Hospital #2**

*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

Greenwood Cem

May 19 1928

20. UNDERTAKER

ADDRESS **2726**

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Beal

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.

