

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

Do not use this space.

18465

**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. **4799**  
 St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **816 Kansas** Ward.....  
 (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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan 17 - 1867**  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
**61 | 3 | 15**

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work **Amusements**  
 (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, Mo.**

10. NAME OF FATHER **John White**  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**  
 12. MAIDEN NAME OF MOTHER **Unkown**  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

14. INFORMANT (Address) **City Hospital**

15. FILED **MAY - 3 1928** **Max C. Standley** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 2 1928**  
 17. I HEREBY CERTIFY That I attended deceased from **Apr 29** 1928 to **May 2** 1928 that I last saw him live on **May 2** 1928 and that death occurred, on the date stated above, at **7:30 a.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Cerebral Hemorrhage - apoplexy**  
 (duration) yrs. mos. da.  
 CONTRIBUTORY (SECONDARY) **740**

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) **Robert D. Sneyd, M.D.**  
**5/2**, 1928 (Address) **City Hospital**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MARKS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **New Orleans** DATE OF BURIAL **5/4 1928**

20. UNDERTAKER **Chapman & Co** ADDRESS **7814 S. Broadway**

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.

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