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

Do not use this space.
19099

1. PLACE OF DEATH
County..... Registration District No. 791
Township St Louis Mo. Primary Registration District No. 1003
City St Louis Mo. (No. 4700 Acme St. ..... Ward)
File No. .....
Registered No. 5518

2. FULL NAME Donald Dana Sinclair
(a) Residence. No. ..... St., 7 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. 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 8th 1926

7. AGE: Years 2 | Months 4 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Indianapolis
(STATE OR COUNTRY) Ind

PARENTS
10. NAME OF FATHER Arthur Sinclair
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ind
12. MAIDEN NAME OF MOTHER Gertrude Gibson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky

14. INFORMANT Arthur Sinclair
(Address) 4700 Acme St

15. FILED MAY 21 1928 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19 1928

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1928, to May 19, 1928, that I last saw alive on May 19, 1928, and that death occurred, on the date stated above, at 3 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

13B
8b Convulsion
(duration) ..... yrs. ..... mos. 5 hrs

CONTRIBUTORY (SECONDARY) Bacillary Dysentery
(duration) ..... yrs. ..... mos. 10 hrs

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) M. A. Schumacher, M. D.
, 19 (Address) 8720 N. Florissant

*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: Bellefontaine
DATE OF BURIAL: May 22 1928

20. UNDERTAKER: Math Herrmann
ADDRESS: 4103 N. Florissant Av

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD