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

Do not use this space.

21946

File No.

Registered No. 6093

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. 3118 Hickory St. Ward)

2. FULL NAME David Thomas

(a) Residence. No. 3118 Hickory St., 18 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Col	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1843

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt.	85	Unknown		

8. OCCUPATION OF DECEASED

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

(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) Texas

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT Anna Thomas
(Address) 1217 Kansas Ave.

15. FILED ..... 19..... REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 6-3 ....., 19 28, to 6-3 ....., 19 28, that I last saw him alive on 6-3 ....., 19 28, and that death occurred, on the date stated above, at 5 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

8 10 Ca (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Gastro Enteritis

Old Age (duration) ..... yrs. 1 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? —

DID AN OPERATION PRECEDE DEATH? No. DATE OF. —

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms

(Signed) L. A. Wattlock, M. D

, 19 (Address) 1501 N. Jefferson

*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 Booker Washington Cem. DATE OF BURIAL 6/7 1928

20. UNDERTAKER R. M. C. Green ADDRESS 3517 Ladele ave.

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