

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(No. *City Hospital*)

File No.....

22241

Registered No.....

6423

St..... Ward)

2. FULL NAME

(a) Residence. No. *418 McPherson* Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *8* yrs. *0* mos. *0* 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) *June 6 1884*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 5 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Elevator Operator*
(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) *Illinois*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT
(Address)

15.

FILED *JUN 18 1928*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 15 1928*

17. I HEREBY CERTIFY That I attended deceased from *June 13 1928* to *June 15 1928* that I last saw *alive* on *June 15 1928* and that death occurred, on the date stated above, at *6:15 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Acute ulcer
Chronic cholecystitis (post-op)
Peritonitis*

CONTRIBUTORY
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Edmund R. Shepley, M.D.*
6/16/28 (Address) *City Hospital*

*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

St. Hope. E. St. Louis

6-18-28

20. UNDERTAKER

ADDRESS

W. L. Woodside

E. St. Louis

WRITE PLAINLY, WITH UNFADING INK--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.

Musgrave.