

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.

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..... City Registration District No. **003**
City **St. Louis** (No. **City Hospital #2**)

22309

File No.
Registered No. **6494** St. Ward)

2. FULL NAME

(a) Residence. No. **3120** **Bell** St., **21** Ward.
(Usual place of abode)

Length of residence in city or town where death occurred **20** 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 **Col.** 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) **Feb. 20, 1876**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
52 **3** **26** **—**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Cook**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Mo.**
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **Anna F. Woodard**
(Address) **City Hospital #2**

15. FILED **20** **1928** **Ken & Stanley**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from **6/12**, 19**28**, to **6/16**, 19**28**, that I last saw him alive on **6/16**, 19**28**, and that death occurred, on the date stated above, at **10:40 P. M.**

THE CAUSE OF DEATH WAS AS FOLLOWS:
Chronic Myocarditis

CONTRIBUTORY (SECONDARY) **90%**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **not known**
IF NOT A PLACE OF DEATH? **no**

DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **clinical**

(Signed) **H. H. Under**, M. D.
, 19 (Address) **City Hosp. #2**

*State the DISEASE CAUSING DEATH, or if 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 **Berkenside, Washington Co.** DATE OF BURIAL **6/20/28**

20. UNDERTAKER **R. M. C. Green** ADDRESS **3517 Laclade**

