

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

Do not use this space.

25480  
7294

**1. PLACE OF DEATH**

County..... Registration District No.....  
Township..... Primary Registration District No.....  
City St. Louis (No. Low Hospital) St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 1516 Cass St., 25 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) April 2 1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
42 3 9

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Concrete Finisher  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer Remier Construction

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Ind

**10. NAME OF FATHER**

Geo. McKee

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Ind

**12. MAIDEN NAME OF MOTHER**

Mary Antiga

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Ind

**14. INFORMANT**

(Address) 1516 Cass St

**15. FILED**

Jul 13 1920 Registrar

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 11 1928

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, and that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Chronic Pneumonia  
131  
Repts White's

**CONTRIBUTORY (SECONDARY)**

W.M.A.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH: 129 W

19. DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) J. W. Kemer, M.D.

(Address) Dep. Comm

\*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**

Calvary Cemetery DATE OF BURIAL July 13 1928

**20. UNDERTAKER**

Central ADDRESS 1841 Cass St

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.

