

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 701
Primary Registration District No. 1003

File No. 25901
Registered No. 7761
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2208 Chestnut St. 21 Ward.

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (if nonresident give city or town and State)

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) Unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>abt. 23</u>	<u>?</u>	<u>?</u>	<u>?</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer ¹⁰⁸⁹
(b) General nature of industry, business, or establishment in which employed (or employer) Railroad
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Miss.
(STATE OR COUNTRY)

10. NAME OF FATHER A. Tucker

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

12. MAIDEN NAME OF MOTHER Unknown

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

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

15. FILED JUL 27 1928 19 Jan. Stanley REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-9-1928

17. I HEREBY CERTIFY, That I attended deceased from 7-9-1928, to 7-9-1928, that I last saw him alive on 7-9-1928, and that death occurred, on the date stated above, at 3:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lob. pneumonia (Right side)

E/O/W (duration) yrs. mos. ds.
CONTRIBUTORY Chronic myocarditis
(SECONDARY) toxin (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Aspiration of pleura
(Signed) F. C. Cunningham, M. D.
, 19 (Address) 2945 Newton

*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 St. Louis DATE OF BURIAL 7/12/28

20. UNDERTAKER W. Richter ADDRESS 3500 Putnam

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.

THIS IS A PERMANENT RECORD

