

**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.....

St. Louis, Mo. (No. Sanitarium)

File No.....

28490

Registered No.....

7916

St. Ward)

2. FULL NAME

Mike Sawyer

(a) Residence. No. 2103 Mullamphy St.,

(Usual place of abode)

13 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 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)

Dec 25, 1867

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, hrs. or min.

60

7

6

8. OCCUPATION OF DECEASED

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

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Unknown

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Rockville

(STATE OR COUNTRY)

Connecticut

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

PARENTS

14.

INFORMANT (Address)

W.R. Summers 5300 Arsenal

15.

FILED

AUG - 2 1928 Max C. Staveland REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Aug. 12 1928

17.

I HEREBY CERTIFY, That I attended deceased from Jan 1928, to Aug 12 1928 that I last saw him alive on July 31 1928, and that death occurred, on the date stated above, at 5:30 A.M.

(THE CAUSE OF DEATH* WAS AS FOLLOWS)

Status Epilepticus

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)

W.R. Summers, M.D.

1928 (Address)

5300 Arsenal

*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

Calvary Cemetery Aug 2 1928

20. UNDERTAKER

ADDRESS

Cullinan Bros 17102 Grand

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.

PERMANENT RECORD

