

**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. 782
 Township St. Louis Primary Registration District No. City Hospital #1
 City St. Louis (No. City Hospital #1) St. St. Louis Ward 21

File No. 29154
 Registered No. 8665

2. FULL NAME

(a) Residence. No. 4170 Olive St. St. St. Louis Ward 21
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown</u>		
7. AGE <u>abt 58</u>	YEARS <u>✓</u>	MONTHS <u>✓</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Labourer</u> (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) Missouri

PARENTS	10. NAME OF FATHER
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) <u>Missouri</u>
	12. MAIDEN NAME OF MOTHER <u>W. W. W. W.</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) <u>Missouri</u>

14. INFORMANT Wm Deaver
 (Address) Coroner Office

15. FILED AUG 27 1923 May C. Stanley
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-20-23
 17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at 11:20 a.m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23A (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) W. M. A. (duration) yrs. mos. da.

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) Wm Deaver M.D.
8/27, 1923 (Address) Dep Coroner
 *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 Tollers Freed DATE OF BURIAL 8-27 1923

20. UNDERTAKER Southern ADDRESS 7315 S Broadway

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.

