

**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. **City Hospital #2**)

File No. **29351**

Registered No. **9113**

St. Ward

2. FULL NAME

(a) Residence, No. **7104 O'Fallons St., 25** Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred **6** 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

Colored

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)

March 1, 1898

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

30

5

30

8. OCCUPATION OF DECEASED

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

Porter

(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)

Texas

10. NAME OF FATHER

John Tompkins

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Texas

12. MAIDEN NAME OF MOTHER

Katherine Duhan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Texas

14.

INFORMANT (Address)

P. Linton City Hospital #2

15.

SEP 12 1928 FILED 1928

W. C. Barker

REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **8-31-1928**

17. I HEREBY CERTIFY, That I attended deceased from **2-6-1928** to **8-31-1928** that I last saw him alive on **8-31-1928**, and that death occurred, on the date stated above, at **5:28 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia 23A
26
36
24 (duration) yrs. mos. ds.
Contributory Potts Disease & Cold
(SECONDARY) Abscess of the Thorax (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **Muscle Tubercular**

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

20. WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **X-ray**

(Signed) **J. G. Birmingham, M.D.**

, 19 (Address) **2945 Sabaton**

*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

Gother Hickson

Sept 15 1928

20. UNDERTAKER

ADDRESS

J. E. Pope

293 Duane

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.

