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

Do not use this space.

31591

1. PLACE OF DEATH
County: St Louis
Township: Carondelet
City: Rock Mo (No. Robert, Rock Hospital St. Ward)
Registration District No. 1123
Primary Registration District No. 6248 B.
File No.
Registered No. 315

2. FULL NAME: Tom Sawyer
(a) Residence. No. 2507 Virginia St., 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. 18 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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Audrey Sawyer.

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 17 1905

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
22	10	5	

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):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY): America

PARENTS
10. NAME OF FATHER: Bud Sawyer
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): America
12. MAIDEN NAME OF MOTHER: Odia Sawyer nee
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): America

14. INFORMANT: Rock Hospital
(Address): Rock Mo.

15. FILED Sept. 23, 1928 L. C. Obrock M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 9.22.1928

17. I HEREBY CERTIFY, That I attended deceased from 9.5.28, to 9.22.1928, that I last saw h. alive on 9.22.1928, and that death occurred, on the date stated above, at 11.45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
about (duration) yrs. 10 mos. ds.

CONTRIBUTORY (SECONDARY): Unknown (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF OUT AT PLACE OF DEATH? Unknown
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? X ray & Sputum
(Signed) A. L. Gallant, M.D.
9-22-28, 19 (Address)

*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: Dyersburg Tenn.
DATE OF BURIAL: 9/24 1928
20. UNDERTAKER: Paschedag V. Co.
ADDRESS: St. Louis

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.

WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

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