

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

32000

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo. (No. City Hospital) St. Ward)

File No.
 Registered No. 9260
 St. Ward)

2. FULL NAME

(a) Residence. No. 1526 Menard St. 23 Ward. (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 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) Aug 4th 1925

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3 1 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Child
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... Arbor Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Benj. A. Howard

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

12. MAIDEN NAME OF MOTHER Ruth Howard

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

14. INFORMANT Ruth Howard
 (Address) 1526 Menard

15. FILED..... 17..... 19..... May C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 15 19 28
 17.

I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that (that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... 7:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock + Injury
(fractured skull)
Struck by Auto Truck
 (Location) St. Louis Mo.

CONTRIBUTORY (SECONDARY) St. Louis Mo.
2:10 P. Accident (Location) St. Louis Mo. ds.

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

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY..... Yes

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) J. W. Kemmer M.D.
9/17/28 (Address) Dep. Comm.

*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 Arbor Mo. DATE OF BURIAL Sept. 18 19 28.

20. UNDERTAKER Brockland ADDRESS St. Louis Mo. 1421 N. 9th

W- PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B. 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.

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