

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

Do not use this space.

34939

1. PLACE OF DEATH

County..... Registration District No. **791**
 Townshp. *St. Louis* Primary Registration District No. **1003**
 City *St. Louis* (No. *City Hospital #2*)..... St. (Ward)

File No.....
 Registered No. **9912**

2. FULL NAME

(a) Residence. No. *26121 Olive (R)* St., *21* Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred *13* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Col.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF *John Casey*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 5, 1889*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
38 11 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *haircutter*
 (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) *La.*

10. NAME OF FATHER *Unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) *Unknown*

12. MAIDEN NAME OF MOTHER *Eliza Mason*

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

14. INFORMANT *Mrs. F. Woodard*
 (Address) *City Hospital #2*

15. *OCT - 9 1928* *Malb Starckoff*
 Filed on 1928 Registrar

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10-4-1928*

17. I HEREBY CERTIFY, That I attended deceased from *10-3-1928*, to *10-4-1928*, and that I last saw him alive on *10-4-2*, 1928, and that death occurred, on the date stated above, at *1:00 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

cerebral thrombosis - 131
left side paralysis - 82A
(cause) - 102

High Blood Pressure (duration) yrs. mos. ds. *1 da.*

CONTRIBUTORY (SECONDARY) *Ch. Nephritis* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *1290*
 IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH. *no* DATE OF.....
 WAS THERE AN AUTOPSY..... *no*

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) *Th. Cunningham*, M. D.
 , 19 (Address) *2945 Fabton*

*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 *Father Dickson Court* DATE OF BURIAL *10/9/1928*

20. UNDERTAKER *J. W. Hughes* ADDRESS *2620 Stanton Ave*

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

