

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

Do not use this space.

354310

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No. **10487**

Township.....

Primary Registration District No. **1003**

Registered No. **10487**

City **St. Louis** (No. **Children's Hospital**)

St. Ward)

2. FULL NAME

(a) Residence. No. **123 Sedgwick** St., **St. Louis** Ward. **St. Louis**

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **Life** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 7 - 1924**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **3 10 16**

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work **At home** 7915 78A (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Mo**

10. NAME OF FATHER **Joe Oaden**

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

12. MAIDEN NAME OF MOTHER **Rose King**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Mo**

14. INFORMANT **M. B. Jacobi** (Address) **500 S. Kingshighway**

15. FILED **ST 25 1928** **Max B. Starkoff** REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 23 1928**

17. I HEREBY CERTIFY, That I attended deceased from **Sept 28**, 19**28**, to **Oct 23**, 19**28**, that I last saw h. s. m. alive on **Oct 23**, 19**28**, and that death occurred, on the date stated above, at **8:30 a.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain abscess -
cause unknown
about (duration) **0** yrs. **3** mos. **15** da.

CONTRIBUTORY **Cerebrospinal meningitis** (SECONDARY) **Staphylococcus** (duration) **0** yrs. **0** mos. **7** da.

18. WHERE WAS DISEASE CONTRACTED **Home** (IF NOT AT PLACE OF DEATH?) **1711 W. Yes** DID AN OPERATION PRECEDE DEATH? **Yes** DATE OF **4-29-28** **10-5-28**

WAS THERE AN AUTOPSY? **Yes** WHAT TEST CONFIRMED DIAGNOSIS? **Examination & autopsy** (Signed) **A. C. Edwards**, M. D.

10-23-1928 (Address) **500 S. Kingshighway** *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 **St. Peter & Paul Cemetery** DATE OF BURIAL **Oct 23 1928**

20. UNDERTAKER **J. N. Gibson & Sons Co** ADDRESS **2842 Meramec**

X. 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.

