

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

Do not use this space.

38349

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

Bethanien

(No.....)

1519 Market St.

File No.....

Registered No.....

10960

St.....

Ward.....

2. FULL NAME

Elyah M Crystal

(a) Residence. No.....

1519 Market St.

St.....

25

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)

Widower

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

Not known

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

May 3 1850

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, hrs. or min.

78

5

5

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)

Sunshine Masine

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ind.

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Not known

14.

INFORMANT

(Address)

Edw. Carol

1519 Market St

15.

FILED - 9 1928

FILED

May 2 1928

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Nov 8, 1928

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19....., and that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... *1036 A.*.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
9/28
W.M.A.

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....

20. WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)

J.W. Kerner M.D.
11/9, 1928

Dep. Coroner

*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

Funeral Home Nov. 8 1928

20. UNDERTAKER

ADDRESS

Funeral Home 456 Delmar

K. 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.

