

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

Do not use this space.

38800

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital # 2**)

File No. ....

Registered No. **11459**

St. ....

Ward) .....

**2. FULL NAME**

(a) Residence No. **3527 Market St.** 18 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **7** 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

**Col.**

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

**Widowed**

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

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

**Jan. 24, 1896**

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

**52 9 27**

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)

**Miss.**

10. NAME OF FATHER

**Robert Givens**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

**Unknown**

12. MAIDEN NAME OF MOTHER

**Unknown**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

**Unknown**

14.

INFORMANT (Address)

**Robert Givens, City Hospital # 2**

15.

FILED

**NOV 24 1928**

**City Hospital # 2**

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **11-21-1928**

17. I HEREBY CERTIFY, That I attended deceased from **9-28-1928** to **11-21-1928** that I last saw him alive on **11-21-1928**, and that death occurred, on the date stated above, at **5:22 A. m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Chol. myocarditis**  
**131**  
**93C**

CONTRIBUTORY (SECONDARY)

**Chol. nephritis** (duration) yrs. mos. da.

18. WHERE DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **no** DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

**W. H. G. Galt**  
**T. E. Cunningham, M.D.**  
**2945 Sahaton**

\*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

**Washington Park**

**Nov. 24, 1928**

20. UNDERTAKER

ADDRESS

**J. C. Thomas**

**3111 Lechloe**

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

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.

