

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

Do not use this space.

38987

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. **11637** St. _____ Ward)

2. FULL NAME

(a) Residence. No. *1304 Chestnut* St., *25* Ward. (If nonresident give city or town and State)
 Length of residence in city or town where death occurred *21* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>male</i>	4. COLOR OR RACE <i>Col.</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Unknown</i>		
7. AGE <i>abh 48</i>	YEARS	MONTHS
	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Labourer</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11-24-1928*
 17. I HEREBY CERTIFY, That I attended deceased from *11-8-1928* to *11-24-1928* that I last saw *h.l.k.* alive on *11-24-1928* and that death occurred, on the date stated above, at *1:50 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
*Pulmonary Tuberculosis
 & Acute Pneumonia
 Pulm.*
 (duration) yrs. *1* mos. *15* da.
 CONTRIBUTORY (SECONDARY) *31*
 (duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Texas*

10. NAME OF FATHER *Chas. James*

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

12. MAIDEN NAME OF MOTHER *Ethel Walker*

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

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

15. FILED *NOV 30 1928* *max B. Stansloff* REGISTRAR

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

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

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Wray & Gal*
 (Signed) *J.E. Cunningham, M.D.*
 , 19 (Address) *2945 Sahuton*

*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 *Washington* DATE OF BURIAL *11/28/28*

20. UNDERTAKER *McGinty* ADDRESS *2500 Rutger*

WRITE PAINLY, 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.

