

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

Do not use this space.

42953

File No. \_\_\_\_\_  
Registered No. 12226  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**1. PLACE OF DEATH**

County \_\_\_\_\_ Registration District No. \_\_\_\_\_  
Township \_\_\_\_\_ Primary Registration District No. 791  
City St. Louis (No. City of St. Louis)

**2. FULL NAME**

(a) Residence No. 1319 Mechanics St. Ward \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	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) <u>Dec 17 - 1926</u>		
7. AGE	YEARS	MONTHS
	<u>1</u>	<u>11</u>
		<u>27</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>mile</u>		
(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) Arkansas

10. NAME OF FATHER John Gaines

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

12. MAIDEN NAME OF MOTHER Effie Hopkins

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

14. INFORMANT (Address) St. Matthew Hospital

15. FILED \_\_\_\_\_, 19 \_\_\_\_\_ REGISTRAR Marie Standif

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 14 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1928 to Dec 14 1928 that I last saw him alive on Dec 14 1928 and that death occurred, on the date stated above, at 4:20 P. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS  
Hydrocephalus  
Bilateral Otitis Media  
159A  
89A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 159A (duration) yrs. mos. ds.

18. WHERE WAS 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) R. Berg M. D.  
12/15 1928 (Address) City Hospital

\*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. Matthew DATE OF BURIAL Dec 15 1928

20. UNDERTAKER E. J. Schram ADDRESS 3125 Lafayette

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.

Paines