

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

Do not use this space.

**1. PLACE OF DEATH**

County \_\_\_\_\_  
Township \_\_\_\_\_  
City St. Louis (Neighborhood) \_\_\_\_\_

Registration District No. 791  
Primary Registration District No. \_\_\_\_\_

File No. 43219  
Registered No. 12525  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence No. 2707 Walnut St Ward 22

Length of residence in city or town where death occurred 2 yrs. 22 mos. 22 ds. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-14-1890

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>38</u>	<u>9</u>	<u>29</u>	

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) Georgia

10. NAME OF FATHER Frank Vickman

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

12. MAIDEN NAME OF MOTHER Rama Gilmore

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

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

15. FILED DEC 22 1928 W. J. Standiford REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/8/1928

17. I HEREBY CERTIFY, That I attended deceased from December 5, 1928, to December 8, 1928 that I last saw him alive on December 19, 1928 and that death occurred, on the date stated above, at 7:10 p. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Streptococcus bacillae  
9" (duration) \_\_\_\_\_ yrs. 4 mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) JA (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 Microscopic  
(Signed) J. J. Thomas M. D.  
12/10/28 (Address) City Hospital #2

\*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 Uni DATE OF BURIAL 12-22-1928

20. UNDERTAKER Watson and Son ADDRESS 2907 Chouteau

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.

