

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

Do not use this space.

43393

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **12704**

City **St. Louis** (No. **4238 N. Ashland Ave.**)

St. Ward

2. FULL NAME

(a) Residence. No. **4238 N. Ashland** 10 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 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 **Colored** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widower**

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt 71

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) **Ga**
(STATE OR COUNTRY)

10. NAME OF FATHER **Unknown**

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 **Stramp Ross**
(Address) **4238 N. Ashland**

15. FILED **19** **1928** **Dec 24** **1928**
C. H. Roberts REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **12/21 1928**

17. I HEREBY CERTIFY That I attended deceased from **Dec 19 1928** to **Dec 21 1928**
that I last saw h. **alive** on **Dec 20 1928**, and that death occurred, on the date stated above, at **9:30 AM**.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

Arterio Sclerosis (duration) **1** yrs. **1** mos. **1** da.

CONTRIBUTORY (SECONDARY) **Arterio Sclerosis** (duration) **1** yrs. **1** mos. **1** da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

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

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Samuel Gifford, M.D.**
Dec 24 1928 (Address) **925 N. Jefferson Ave**

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDE.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Greenwood** DATE OF BURIAL **12/29 1928**

20. URDERTAKER **C. N. Roberts** ADDRESS **3035 Lucas**

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.

