

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

Do not use this space. **47**
43654 49

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. **7 83**
St. **L.** Ward)

2. FULL NAME

(a) Residence. No. **3351 Marquette** St., **18** Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **4** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male	4. COLOR OR RACE Negro	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-29-1906		
7. AGE	YEARS	MONTHS
	22	6
		0
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work..... Labour		
(b) General nature of industry, business, or establishment in which employed (or employer)..... 11th St		
(c) Name of employer..... 19th St		

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **December 29 1928**
17. I HEREBY CERTIFY, That I attended deceased from **December 22, 1928, to December 29, 1928** that I last saw him alive on **December 29, 1928**, and that death occurred, on the date stated above, at **12¹⁰ M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Perforating gastric ulcer
acute diffuse peritonitis
CONTRIBUTORY (SECONDARY) **perforating gastric ulcer**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **12/23/28**
WAS THERE AN AUTOPSY? **no**
WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**
(Signed) **J. J. Thomas** M. D.
(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 **Calvary Cem.** DATE OF BURIAL **Jan 3 1929**
20. UNDERTAKER **Russell Und. Co** ADDRESS **2732 Pine St**

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

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

15. FILED **2 15 1928** REGISTRAR **Max C. Barker**

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.

