

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.

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

Do not use this space.

1689

1. PLACE OF DEATH

County JacksonRegistration District No. 399Township 1stPrimary Registration District No. 1002City St. ClairFile No. 280Registered No. 280St. Ward

2. FULL NAME

(a) Residence No. 1300 Olive St. Ward

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Anna Desmon

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

Oct 15 - 1861

7. AGE

YEARS 68 MONTHS 7 DAYS 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Crozier Foreman

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Clair

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 Anna Desmon
(Address) 1300 Olive

15.

FILED 1-29-29 M. M. Crowe
asst REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

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

Jan 19 1929

17.

I HEREBY CERTIFY, That I attended deceased from 15 to 19that I last saw h. alive on 12, 1929, and that death occurred, on the date stated above, at 12

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma Stomach
Gastric Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Carcinoma Stomach

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF noWAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Stanley M. Ray, M. D.1/19, 1929 (Address) 1300 Olive

*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

DATE OF BURIAL

Funeral Home Jan 19 1929

20. UNDERTAKER

Rose Henderson St. Clair

