

X. 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.

1777

1. PLACE OF DEATH

County Jackson
 Township Law
 City Rock

Registration District No.

399

Primary Registration District No.

1002

File No.

Registered No.

369

St.

Ward)

2. FULL NAME

(a) Residence. No. 1717 E. 18th 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.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

PERSONAL AND STATISTICAL PARTICULARS**3. SEX**

Female

4. COLOR OR RACE

Colored

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)**

May 17-1925

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ____ hrs. or ____ min.

3

8

86

8. OCCUPATION OF DECEASED

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

Home 181

(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)

Missouri

10. NAME OF FATHER

Le Roy McChue

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

12. MAIDEN NAME OF MOTHER

Bertha McChue

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

14.INFORMANT
(Address)Bertha McChue
1717 E. 18th St**15.**

FILED

12529

M. M. Cron
Asst REGISTRAR**MEDICAL CERTIFICATE OF DEATH****16. DATE OF DEATH (MONTH, DAY AND YEAR)**

1-23-1929

17.

I HEREBY CERTIFY That I attended deceased from

19.

19.

that I last saw him alive on

19.

and that

death occurred, on the date stated above, at

m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental - Burns
 (Clothing caught fire)

CONTRIBUTORY (SECONDARY)

(duration)

yrs.

mos.

da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8

DID AN OPERATION PRECEDE DEATH

DATE OF

WAS THERE AN AUTOPSY

no

WHAT TEST CONFIRMED DEATH

(Signed)

M. D.

(Address)

Deputy Coroner

*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**

Highland

1-26 1929

20. UNDERTAKER**ADDRESS**

Various Bros

1729 Lydia

CAUSE OF DEATH is stated as that it was
classified. Exact statement of C. H. B. is
YITZAN and that it was classified. Exact statement of C. H. B. is
YITZAN and that it was classified. Exact statement of C. H. B. is

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

ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....

Registration District No. 399

File No.

Township.....

Primary Registration District No. 1012

Registered No. 369

City St. Louis (No.)

St. Ward)

2. FULL NAME

(a) Residence. No. 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

F

4. COLOR OR RACE

Col

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

S

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

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

7. AGE

YEARS

MONTHS

DAYS

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

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

(Address)

15.

FILED

1/25 29 M. M. Brown
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 23 1929

17.

I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

that I last saw him after noon, 19....., and that
death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental Burns
Clothing Caught Fire

CONTRIBUTORY
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) M. D.

, 19 (Address)

*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

20. UNDERTAKER

ADDRESS

19

SUPPLEMENT

26

PHYSICIAN'S should state
date and of OCCUPATION is very important.

ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

REGISTER

S-1777