

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

Do not use this space.

2090

**1. PLACE OF DEATH**

County Jefferson Registration District No. 420 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3027 Registered No. ✓  
 City St. Louis (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Still born Carl Forcher and Alice Cortway  
 (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** M **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) \_\_\_\_\_

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of** \_\_\_\_\_

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** 10-20-1928

**7. AGE** YEARS \_\_\_\_\_ MONTHS \_\_\_\_\_ 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 \_\_\_\_\_

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

**10. NAME OF FATHER** Carl Forcher

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

**12. MAIDEN NAME OF MOTHER** Missouri

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

**14. INFORMANT** Minister Fisher  
 (Address) 123 1/2 St. \_\_\_\_\_

**15. FILED** 4/4/29 St. Louis REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Jan - 1 1929

I HEREBY CERTIFY, That I attended deceased from Jan 28 1929 to Jan 28 1929 that I last saw him on the day of his death, 1929, and that death occurred on the date stated above, at St. Louis, Mo.

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

Premature birth

**CONTRIBUTORY (SECONDARY)** 16/10 (duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH? \_\_\_\_\_

**18. DID AN OPERATION PRECEDE DEATH? DATE OF** \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signature) Walter G. Jones M. D.

(Address) 123 1/2 St. \_\_\_\_\_

\*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** Worship Center **DATE OF BURIAL** 1/21/29

**20. UNDERTAKER** W. J. \_\_\_\_\_ ADDRESS \_\_\_\_\_

K. 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.

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