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

Do not use this space.

4177

1. PLACE OF DEATH

County..... Registration District No. 791 1002

Township..... Primary Registration District No.....

City St. Louis, (No. 4057 Wyoming Avenue. St. Ward)

File No.....

Registered No. 800

2. FULL NAME Bennett T. James.

(a) Residence. No. 4057 Wyoming Street St., 16 Ward.
(Usual place of abode)

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.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 2. 1910.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	18	10	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At school.

(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) East St. Louis, Ills

PARENTS

10. NAME OF FATHER Charles A. James.

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mitchie, Ills.

12. MAIDEN NAME OF MOTHER Sarah L. Klinkhardt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Hecker, Ills.

14. INFORMANT Chas. A. James

(Address) 4057 Wyoming Street

15. FILED ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/15 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan. 9th, 1929, to Jan. 15th, 1929, that I last saw h.... alive on Jan. 15th, 1929, and that death occurred, on the date stated above, at 2:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia (Bilateral)

10 A

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. 6 ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? at place of death

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam

(Signed) A. F. Clay, M. D

, 19 (Address) 3150 Morgan ford.

*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
SS. Peter & Paul Cemetery	Jan. 18. 1929

20. UNDERTAKER H. Gebbeke Co. ADDRESS 2842 Meramec

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD