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

Do not use this space.

4192

**1. PLACE OF DEATH**

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 816

City St. Louis (No. City Hospital #2 St. ..... Ward)

**2. FULL NAME** Earl Segars

(a) Residence. No. 4028 Finney St., 11 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 7 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: Col.
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) Aug. 24, 1901

7. AGE: Years 27 | Months 4 | Days 22 | If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(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): Ga.

PARENTS

10. NAME OF FATHER: Henry Segars
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ga.
12. MAIDEN NAME OF MOTHER: Fannie Pittman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ga.

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

15. FILED 17, 19.. Max O. Starker, Registrar

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from 1-11-, 1929, to 1-16-, 1929, that I last saw him alive on 1-16-, 1929, and that death occurred, on the date stated above, at 5:15 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pulmonary Tuberculosis

23A

(duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

0 DID AN OPERATION PRECEDE DEATH? 120 DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X ray & Gab

(Signed) T. E. Cunningham, M. D.

, 19 (Address) 2945 Lawton

*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: Greenwood
DATE OF BURIAL: 1-18 1929

20. UNDERTAKER: Manuel Undt Co
ADDRESS: 4059 Finney Ave

237
2
2
2

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

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.