

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

Do not use this space.

7819

1. PLACE OF DEATH

County St. Louis Registration District No. 1784
 Township St. Armand Primary Registration District No. 6030
 City Prospect Hill (No. _____) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME

(a) Residence. No. St. Louis (Metton) Ward _____
 (Usual place of abode) St. Louis Ave. Prospect Hill (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. 2 mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>0</u> ✓	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>0</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 3 - 1929

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
		<u>2</u> ✓		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 0
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer 0

9. BIRTHPLACE (CITY OR TOWN) Prospect Hill
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Joe Metton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Maynard Ark

12. MAIDEN NAME OF MOTHER Iva Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Reyn. Ark

14. INFORMANT Father
 (Address) Prospect Hill Mo.

15. FILED Feb 19 1929 O. S. Schumaker
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 4 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 4, 1929, to Feb 4, 1929, that I last saw h. 0 alive on 0 5:30 P.M., and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Stillborn

161 H

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

CONTRIBUTORY (SECONDARY) _____

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

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) Wm. A. Knight, M. D.

2-5, 1929 (Address) 8617 Kalls Rd

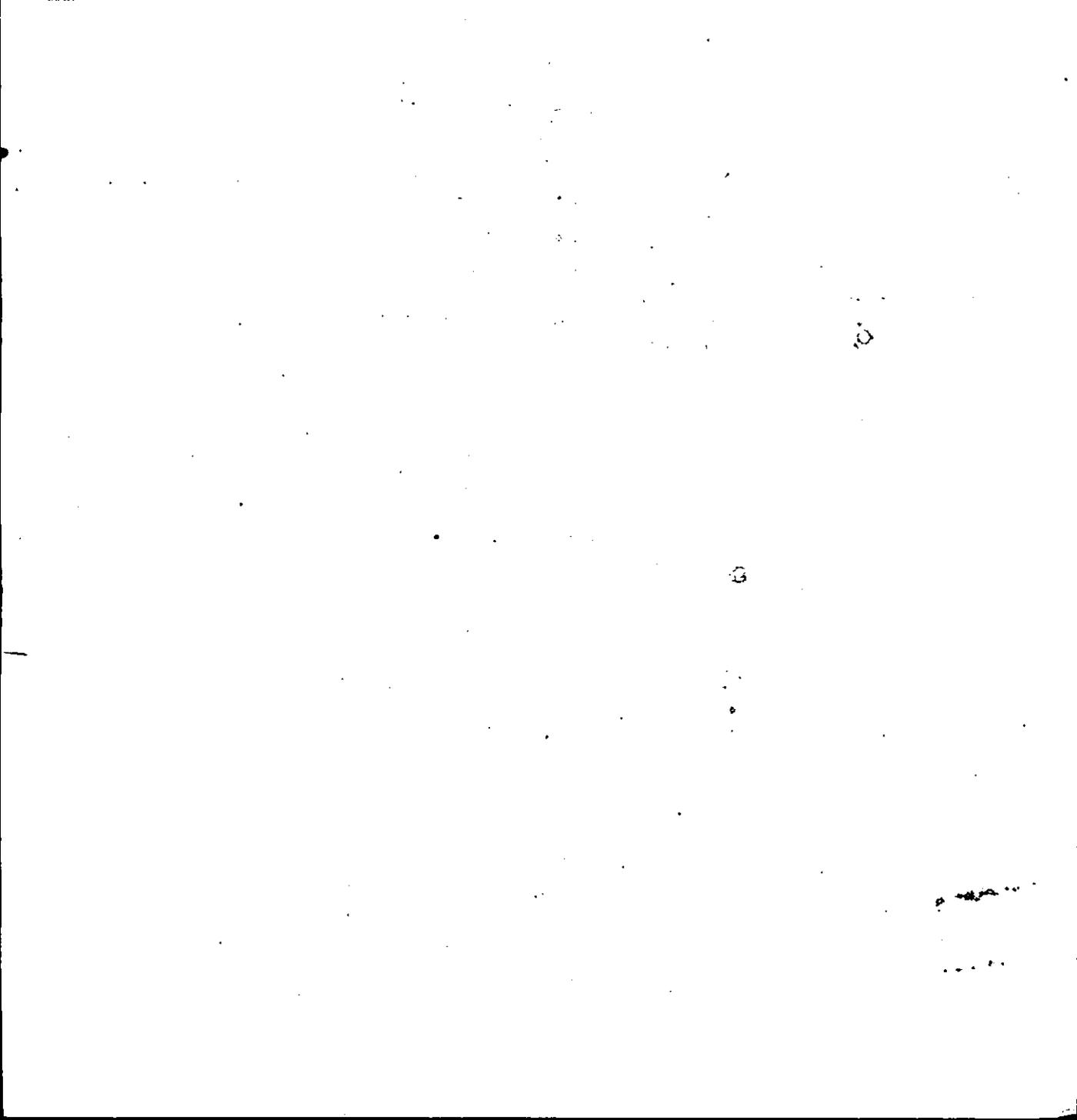
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Fetus kept for instructions 19

20. UNDERTAKER Hospital ADDRESS

Westminster Hospital St. Louis



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 784 File No. 7819
 Township St. Ferdinand Primary Registration District No. 6030 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence No. Melton Glen Dale Ave Prospect Hill (If nonresident give city or town and State)
 (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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>2-2-1929</u>		
7. AGE YEARS	MONTHS	DAYS
<u>1</u>	<u>1</u>	<u>2</u>
If LESS than 1 day, 2 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		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-4-1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis

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

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 _____

14. INFORMANT (Address) _____

15. FILED 6-8-1929 O. V. Schwede REGISTRAR

SUPPLEMENTARY 1602

REGISTRATION SHALL NOT BE REQUIRED

618L-S