

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

Do not use this space.

8311

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 100<sup>st</sup>  
 City St. Louis, Mo. City Infirmary File No. ....  
Zachary Taylor Colclozier Registered No. 1953  
 St. .... Ward)

**2. FULL NAME**.....  
 (a) Residence. No. City Infirmary 13 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**

**MEDICAL CERTIFICATE OF DEATH**

**3. SEX** Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** married  
**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** Sarah Colclozier  
**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Aug. 4, 1876  
**7. AGE** YEARS 82 MONTHS 6 DAYS 5 If LESS than 1 day, hrs. or min.

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 2/9 19 29  
**17. I HEREBY CERTIFY, That I attended deceased from** Aug 16, 1928, to Feb 9, 1929  
 that I last saw h. alive on Feb 9, 1929, and that death occurred, on the date stated above, at City Infirmary.

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

Chronic Myocarditis

**CONTRIBUTORY (SECONDARY)** None  
 (duration) yrs. mos. da.  
 (duration) yrs. mos. da.

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH: unknown

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Washington D.C.

**19. DID AN OPERATION PRECEDE DEATH?** No DATE OF.....  
**20. WAS THERE AN AUTOPSY?** No

**10. NAME OF FATHER** J

**WHAT TEST CONFIRMED DIAGNOSIS?** Chronic Myocarditis  
 (Signed) Myron C. Paul, M. D.

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

**12. MAIDEN NAME OF MOTHER** J

(Address) City Infirmary  
 2/10, 1929

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

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

**14. INFORMANT (Address)** Harold Holbrook 5800 Broadway

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** Calvary Cemetery **DATE OF BURIAL** 2/12/1929

**15. FILED** May 21 1929

**UNDERTAKER** Berquist & Co. 3661 Washington **ADDRESS**

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.

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REGISTRAR

