

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

Do not use this space.

12581

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis (No. City Hospital #2)

File No.....
Registered No. 3109
St. Ward)

2. FULL NAME

Walter Jefferson
(a) Residence. No. 2319 Market St., 21 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

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) Dec. 22, 1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ___ hrs. or ___ min.
34 | 2 | 19

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) Elkton
(STATE OR COUNTRY)

10. NAME OF FATHER Jerry Jefferson

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

12. MAIDEN NAME OF MOTHER Missie Clason

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

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

15. FILED May 21 1929
REGISTRAR W. C. Starbuck

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-11-1929

17. I HEREBY CERTIFY, That I attended deceased from 2-1-1929 to 3-11-1929, and that I last saw him alive on 3-11-1929, and that death occurred, on the date stated above, at 10:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23A (duration) yrs. 5 mos. da.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? X-ray & lab
(Signed) K. Cunningham, M.D.
, 19 (Address) 2945 Hawthorn

*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 Elkton Ky DATE OF BURIAL 3-14 1929

20. UNDERTAKER Watson and Son ADDRESS 2941 Hawthorn

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.

237
2
2
2

