

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

Do not use this space.

12714

File No. _____
Registered No. **3249**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **701**
Township _____ Primary Registration District No. **1000**
City **St Louis** (No. **City 10000**)

2. FULL NAME **Edward Lacy**

(a) Residence No. **645 Mitchell** St. **4** Ward.

Length of residence in city or town where death occurred **11** 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 **White** 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) **May 12 - 1908**

7. AGE YEARS MONTHS Days If LESS than 1 day, _____ hrs. or _____ min.
20 10 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Waiter**
(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) **Mississippi**

10. NAME OF FATHER **Cumett Lacy**

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

12. MAIDEN NAME OF MOTHER **Willa Addes**

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

14. INFORMANT (Address) **Dr. R. Berg**

15. FILED **MAR 15 1929** **Ray C. Starnes** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 14 1929**

17. I HEREBY CERTIFY, That I attended deceased from **March 27 1929** to **March 14 1929** that I last saw him alive on **March 14 1929**, and that death occurred, on the date stated above, at **4:30 p.m.**

THE CAUSE OF DEATH WAS AS FOLLOWS:

Lobar Pneumonia
16 1/2 (duration) yrs. mos. **15** ds.

CONTRIBUTORY (SECONDARY) **1010** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH **No**

DID AN OPERATION PRECEDE DEATH **No** DATE OF _____

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **R. Berg** M. D.
3/15 1929 (Address) **City 10000**

*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 **Osceola Ark** DATE OF BURIAL **3/16 1929**

UNDERTAKER **Croyhard 7146 Manchester** 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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Lucy.