

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

Do not use this space.

13022

File No. **3577**
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City St. Louis (No 4175 @ Fairfax Avenue)

2. FULL NAME Wesley Arnold

(a) Residence No. 4175 C Fairfax St. 11 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE Negro	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 16, 1851		
7. AGE YEARS 77	MONTHS 11	DAYS 5
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		

9. BIRTHPLACE (CITY OR TOWN) **Unknown**
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)	12. MAIDEN NAME OF MOTHER
	12. MAIDEN NAME OF MOTHER	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)	

14. INFORMANT Wesley Arnold
(Address) 4175 C Fairfax Avenue

15. FILED 1929 Wesley Arnold REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **3-21 1929**
17. I HEREBY CERTIFY, That I attended deceased from **3-9**, 1929, to **3-21**, 1929, that I last saw him alive on **3-21**, 1929, and that death occurred, on the date stated above, at **6 30 PM**.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lungs inflamed
11B (duration) yrs. mos. **11** ds.
CONTRIBUTORY (SECONDARY) **11B** (duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? **no** DATE OF _____
WAS THERE AN AUTOPSY? **no**
WHAT TEST CONFIRMED DIAGNOSIS **Physical**
(Signed) O. J. P. [Signature], M. D.
, 10 (Address) 2746 Franklin

*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 **Washington Park** DATE OF BURIAL **March 24 1929**

20. UNDERTAKER **Gates Funeral Home** ADDRESS **4107 Finney**

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.

