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

Do not use this space.

13197

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 3757

City St Louis (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Jim Mask

(a) Residence. No. 118a Spruce St., 25 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 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: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: 1852

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE: abt 77 YEARS; MONTHS: ?; DAYS: ?; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Janitor
(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): Tenn.

PARENTS

10. NAME OF FATHER: Archie Mask
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Tenn.
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Portella Sexton
(Address): City Hospital #2

15. FILED MAR 28 1929 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): 3-24-1929

17. I HEREBY CERTIFY, That I attended deceased from 2-9-, 1929, to 3-24-, 1929 that I last saw him alive on 3-24-, 1929, and that death occurred, on the date stated above, at 9:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chr. Nephritis
131
930
..... (duration) ..... yrs. 11 mos. ..... ds.

CONTRIBUTORY (SECONDARY): Chr. Myocarditis
..... (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? .....
WHAT TEST CONFIRMED DIAGNOSIS? False
(Signed) T. E. Cunningham, M.D.
, 19 (Address) 2965 Sawton

*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: Booker Washington
DATE OF BURIAL: 3/28 1929

20. UNDERTAKER: R M C Greene
ADDRESS: 3517 Laclede

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.

236
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31