

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City *St. Louis, Mo.* (No. *30462*)

781
1003
File No. *16297*
Registered No. *4336*
St. Ward)

2. FULL NAME

(a) Residence. No. *30462 Thomas* St., *91* Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *18* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* | 4. COLOR OR RACE *col* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Ethel Whitley*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *1-30-18910*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *37 2 11*

8. OCCUPATION OF DECEASED *Coal room boy*
(a) Trade, profession, or particular kind of work *Self Employed*
(b) General nature of industry, business, or establishment in which employed (or employer) *his own*
(c) Name of employer

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

PARENTS

10. NAME OF FATHER *James Whitley*

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

12. MAIDEN NAME OF MOTHER *Arday Whitley*

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

14. INFORMANT *Ethel Whitley*
(Address) *3046 Thomas St*

15. *APR 13 1929*
FILED *13 1929*

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 9 - 1929*

17. I HEREBY CERTIFY That I attended deceased from *12-27-1928* to *4-9-1929* and that I last saw him alive on *4-9-1929*, and that death occurred, on the date stated above, at *3:50 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute capillary Bronchitis
1078
100B 190
(duration) yrs. mos. *107* da.
CONTRIBUTORY *exposure to cold*
(SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: *at place of death*

9 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS: *spec*

(Signed) *A. W. Johnson*, M. D.

4-10-1929 (Address) *4039 a Hinney*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE 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 *April 13 29*

20. UNDERTAKER *A. L. Beal* ADDRESS *2726 Lucas*

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis (No.) St. Ward)

File No.
 Registered No. 4336

2. FULL NAME

Belvie Whitley
 (a) Residence. No. St. 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 M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer)..... (duration) yrs. mos. ds.
 (c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT..... (Address)

15. FILED JUN 28 1932 Max C. Standoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 9 - 1929

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h. alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)....., M. D.

, 19 (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

S-16297