

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

Do not use this space.

16336

1. PLACE OF DEATH

County..... Registration District No. 791
 Townshp..... Primary Registration District No. 3003
 City St. Louis (No. City Hospital #1) St. _____ Ward _____

File No. 4876
 Registered No. _____

2. FULL NAME

(a) Residence. No. 1000 Dickson St. 21 Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. 1 mos. 8 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 25 - 1899

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>49</u>	<u>10</u>	<u>2</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk
 (b) General nature of industry, business, or establishment in which employed (or employer). _____
 (c) Name of employer Polar Wave Sec. Fuel Co.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER

James Honeay

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

14.

INFORMANT. Margaret Honeay
 (Address) 1000 Dickson St.

15.

FILED APR 15 1929 M. C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 13 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 7:50 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & injuries (Fract. Sternum) due to falling from porch at residence 186A
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

Accident
 (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? yes

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) John Shirley, M.D.

4/15 1929 (Address) Deputy Coroner

*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

Calvary DATE OF BURIAL Apr 16 1929

20. UNDERTAKER

Wacker-Helders ADDRESS 2331 S. Bluff

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.

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