

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

Do not use this space.

16451

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis, Mo. No. 5600 Arsenal

File No. 4548
 Registered No. _____
 St. 24th Ward

2. FULL NAME Levin, Mc Mullen

(a) Residence. No. 1421 Benton St., 26 Ward.
 (Usual place of abode)

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. (If nonresident give city or town and State)

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 wife of Carter Mc Mullen

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 26-1900

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____hra. or _____min.
	29	0	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Unknown
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Wielred Mc Mullen

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Miss May Headrick
 (Address) Isolation Hospital

15. W. C. Starkey REGISTRAR
 APR 19 1929

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/18 1929

17. I HEREBY CERTIFY, That I attended deceased from 4/12, 1929, to 4/18, 1929 that I last saw him alive on 4/18, 1929, and that death occurred, on the date stated above, at 1:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis, Meningococci
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED 1421 Benton
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
 WAS THERE AN AUTOPSY? No. DATE OF _____
 WHAT TEST CONFIRMED DIAGNOSIS? Culture
 (Signed) Cecil H. G. The, M. D.
4/18 1929 (Address) 700 Arsenal St.

*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 Westfork Missouri DATE OF BURIAL 4/19 1929

20. UNDERTAKER Choffment U & Co ADDRESS 7812 So Bdm

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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