

**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. 791
 Township St. Louis Mo. Primary Registration District No. 1003
 City St. Louis Mo. (No. 2947^a Clark Ave) St. _____ Ward _____

File No. 19789
 Registered No. 5400

2. FULL NAME

Jonnie Givens Jr.
 (a) Residence. No. 2947^a Clark Ave St. 12 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. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Baby</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Baby</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 9/1929</u>		
7. AGE	YEARS	MONTHS
		DAYS
		IF LESS than 1 day, hrs. or min.
		<u>6</u>

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

St. Louis Mo.
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Jonnie Givens</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Shelby Miss</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Elsie Nick</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Parisburg Miss</u> (STATE OR COUNTRY)

14.

INFORMANT Jonnie Givens
 (Address) 2947^a Clark Ave

15.

FILED MAY 15 1929 Max C. Stanley
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May - 10 - 1929
 17. I HEREBY CERTIFY, That I attended deceased from 5-10-, 1929, to 5-15-, 1929, that I last saw him alive on 5-15-30, 1929 and that death occurred, on the date stated above, at 2-2 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Sepsis
Secondary
Acute Sepsis
 (duration) yrs. mos. 5 ds.
 (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED unknown
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no. DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
 (Signed) L. J. Mott, M. D.

5-15-1929 (Address) 239th S. Jefferson

*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 Cemetery DATE OF BURIAL 5/16, 1929

20. UNDERTAKER Blum Bros. ADDRESS 2152 Jeff Ave

WRITE PAINLY, 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.

