

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

Do not use this space.

20121

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
1003

File No.
Registered No. **5784**
St. Ward)

2. FULL NAME

Edward Carl Termini R.P. Camp

(a) Residence. No. *Madison Ill. St. 22* Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 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 *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *about 55*

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY)

10. NAME OF FATHER *Edward*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Edward Camp*
(Address) *Madison Ill*

15. FILED **MAY 26 1929** 19 *May 26 1929*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-24* 19 *29*

17. I HEREBY CERTIFY, That I attended deceased from *5-20* 19 *29*, to *5-23* 19 *29*

that I last saw him alive on *5-23* 19 *29*, and that death occurred, on the date stated above, at *1045 P* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Gastric enteritis
1708
1929

(duration) yrs. mos. da. *10*

CONTRIBUTORY (SECONDARY) *Alcoholism*
(duration) yrs. mos. da. *10*

16. WHERE WAS DISEASE CONTRACTED *Madison Ill*
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Physical, autopsy*

(Signed) *Howard D. Stucky*, M. D.

, 19 (Address) *2024 W Jeff*

*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 *May 27 19 29*

20. UNDERTAKER *Bessie Gibaux* ADDRESS *1138 1/2 6 St*

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.

