

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

Do not use this space.

23043

791

1003

File No.

Registered No. **6474**

St. Ward)

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City St. Louis (No. St. Johns Hospital)

2. FULL NAME

(a) Residence. No. 1344 Temple St. St. 6 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 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 Grace L. Gaylord

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12/18-1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 5 28

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

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

10. NAME OF FATHER Thos. Gaylord

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

12. MÄIDEN NAME OF MOTHER Miss Brannin

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

14. INFORMANT Grace L. Gaylord (Address) 1344 Temple Place

15. FILED JUN 17 1929 Miss C. Standif REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-16-1929

17. I HEREBY CERTIFY, That I attended deceased from 5-23-29 19....., to 6-16-1929, 19....., and that I last saw him alive on 6-15-29, 19....., and that death occurred, on the date stated above, at 5:15 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic valvular disease of heart.
Acute Regurgitation of mitral
A involvement & consequent
decompensation (duration) 3 yrs approx ds.
CONTRIBUTORY (SECONDARY) Syphilitic
Unknown (duration) 15 yrs approx ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical (H.P. etc)
Cement J. Barnes M. D.

(Signed) 6/16/1929 (Address) 515 Wall St. St. Louis

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Louisville Ky DATE OF BURIAL June 17 1929

20. UNDERTAKER Alexander & Sons 6175 Del... ADDRESS

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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324 E. Swan Ave Webster 16051

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