

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

Do not use this space.

**1. PLACE OF DEATH**

County St. Louis  
Township Carondelet  
City Koch

Registration District No. 1123

Primary Registration District No. 6248

File No. 25753-a  
Registered No. 304  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Earl Chadd

(a) Residence. No. 1012 Chouteau St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred  yrs. 8 mos. 15 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 or (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 29 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
29 7 0

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

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

10. NAME OF FATHER Thornton Chadd

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

12. MAIDEN NAME OF MOTHER Virg. Montgomery

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

PARENTS

14. INFORMANT R Koch Hospital Records  
(Address) Koch, Mo.

15. FILED Aug 4 1929 L. C. Obrod M. U  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29, 1929

17. I HEREBY CERTIFY That I attended deceased from Nov. 1, 1928 July 29, 1929 that I last saw him alive on July 29, 1929, and that death occurred, on the date stated above, at 4 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pulmonary Tuberculosis

About \_\_\_\_\_ (duration) 1 yrs. 3 mos. \_\_\_\_\_ ds.

CONTRIBUTORY Unknown  
(SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH, \_\_\_\_\_  
DATE OF \_\_\_\_\_  
DISEASE PRECEDE DEATH \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

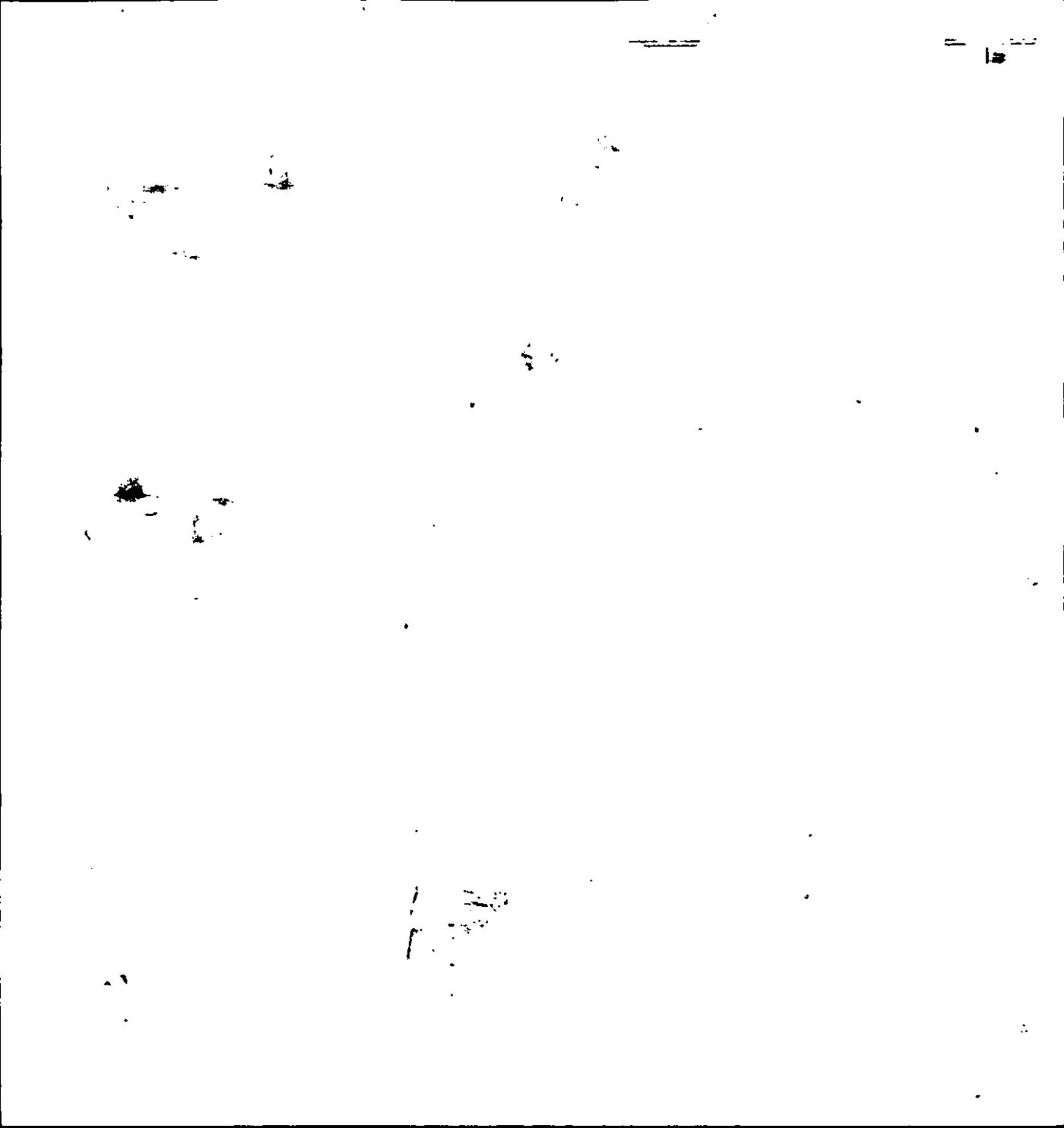
WHAT TEST CONFIRMED DIAGNOSIS X Ray & Sputum  
(Signed) Chas. S. Rosen, M. D.

7/29/29 (Address) Koch Hospital

\*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 Anatomical Board DATE OF BURIAL Aug 14 1929

20. UNDERTAKER St. Louis ADDRESS \_\_\_\_\_



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Louis Registration District No. 1123 File No. \_\_\_\_\_  
 Township Cornudet Primary Registration District No. 6248 Registered No. 300  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward \_\_\_\_\_)

**2. FULL NAME**

Earl Chadd  
 (a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

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

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

14. INFORMANT \_\_\_\_\_

(Address) \_\_\_\_\_

15. FILED Mon 30 19 29 L. C. Brooks MD REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 19 29

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_ that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (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? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19 (Address) \_\_\_\_\_

\*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

DATE OF BURIAL

Anatomical Board Aug 4 19 29

20. UNDERTAKER

ADDRESS

City Undertaker St Louis

THIS SHALL NOT RECEIVE A CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-25753a