

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

Do not use this space.

**26537**

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis*

Registration District No. **791**  
**1003**

File No.....  
Registered No. **7803**  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. *5033 Dawson* St., *7* 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** *Mary Maxwell*

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** *Sept. 13 1882*

**7. AGE** YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
*46*      *10*      *13*

**8. OCCUPATION OF DECEASED**

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

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** *Mo*

**10. NAME OF FATHER** *Mary Maxwell*

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

**12. MAIDEN NAME OF MOTHER** *Delia Farmwood*

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

**14. INFORMANT** *Mary Maxwell*  
(Address) *5033 Dawson Ave*

**15. FILED** *11 20 1929* *Wm C. Starker* REGISTRAR

**2** **MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** *July 26 1929*

**17. I HEREBY CERTIFY, That I attended deceased from** *July 24* 19*29*, to *July 26* 19*29* that I last saw him alive on *July 26* 19*29*, and that death occurred, on the date stated above, at *1:13 P.* m.

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

*Tuberculous meningitis*  
*23 A*  
*2:17 A*

(duration) ..... yrs. .... mos. *12* ds.  
**CONTRIBUTORY (SECONDARY)** *Pulmonary tuberculosis*  
*unknown* (duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....  
**21** DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....  
WAS THERE AN AUTOPSY? *Yes*  
WHY TEST CONFIRMED DIAGNOSIS? *Autopsy*  
(Signed) *Samuel B. Grant* M. D.  
*July 27, 1929* (Address) *3720 Washington*

\*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** *Belmont Cem.* **DATE OF BURIAL** *July 29, 1929*  
**20. UNDERTAKER** *Whehmann Funeral* **ADDRESS** *1905 Union*

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.

RECORD

THIS IS A PERMANENT RECORD

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Reviews