

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

Do not use this space.

26669

**1. PLACE OF DEATH**

County .....

Registration District No. **791**

Township **St. Louis, Mo.**

Primary Registration District No. **1003**

City **St. Louis, Mo.**

No. **City Hospital # 2**

File No. ....

Registered No. **7971**

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **2703 Lucas** St. **21** Ward.

Length of residence in city or town where death occurred **Life** 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 **col.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **6-14-1928**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	1	1	12	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **nil 118C 157D**  
 (b) General nature of industry, business, or establishment in which employed (or employer) .....  
 (c) Name of employer .....

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER **James Tainter**

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

12. MAIDEN NAME OF MOTHER **Josephine Sowiler**

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

14. INFORMANT **Myrtle Creath**  
 (Address) **City Hospital #2**

15. FILED **AG-1** 19 **1929** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **7-26-1929**

17. I HEREBY CERTIFY, That I attended deceased from **7-26-1929** to **7-26-1929** that I last saw him alive on **7-26-1929** and that death occurred, on the date stated above, at **8:25** m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: **8 P.M.**

**Acute Gastric Dilatation** (duration) yrs. mos. **3 hours**

CONTRIBUTORY (SECONDARY) **Pylosic Stenosis (congenital)** (duration) yrs. mos. ....

**18. WHERE WAS DISEASE CONTRACTED**

NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH. DATE OF .....

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS **physical + autopsy**  
 (Signed) **H. E. Hale** M. D.

**7/27/29** (Address) **City Hospital #2**

\*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 **Greenwood** DATE OF BURIAL **7/30 1929**

20. UNDERTAKER **C. W. Roberts** ADDRESS **3035 Lucas**

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.

