

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

Do not use this space.

26671 <sup>a</sup>

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

File No. ....

Township.....

Primary Registration District No. **1003**

Registered No. **8003**

City **St. Louis** (No. **No. Baptist Lane**, St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **6682 N. Park Ave.** St. **4** Ward.

(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)

**Single**

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

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MARRIAGE NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

**July 31, 1929**

17.

I HEREBY CERTIFY, That I attended deceased from **July 23, 1929**, to **July 30, 1929** that I last saw him alive on **July 30, 1929** and that death occurred, on the date stated above, at **7:30 a.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Toxic Adenoma Thyroid Gland**  
**Chronic Myocarditis**  
**Malignant Adenoma of Thyroid Gland** (duration) **10** yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

**Acute Thyrotoxicosis**  
**Hypertension of Thyroid Gland** (duration) **5** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **July 25**

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **B. W. Sleeter, M. D.**

**7/31, 1929** (Address) **Mo. Baptist 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

DATE OF BURIAL

**Calvary Cem.** **Aug 3, 1929**

20. UNDERTAKER

ADDRESS

**Geo. W. Clark** **1125**  
**Madison Ave.**

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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*Handwritten text at the top left corner, possibly a signature or date.*