

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

Do not use this space.

29445

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis (No. 3608, Arsenal)

File No. 8620  
Registered No. ....  
St. 24th (Ward)

**2. FULL NAME** Thomas Alfred Heath

(a) Residence. No. 1829 Olive St. St. 21 Ward. ....  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 0 yrs. 2 mos. 30 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 Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 27, 1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<u>9</u>	<u>25</u>	<u>25</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. none  
(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 Thomas Heath

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

12. MAIDEN NAME OF MOTHER Ide Thompson

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

14. INFORMANT L. Kroner  
(Address) 5608 Arsenal

15. FILED..... 19.....  
May 11 1929  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/22 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929 to Aug 22, 1929 that I last saw him alive on Aug 27, 1929 and that death occurred, on the date stated above, at 9:00 A.M.

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

Pertussis

(duration) yrs. mos. 19 da.  
CONTRIBUTORY Acute pneumonia  
(SECONDARY) Secondary (duration) yrs. mos. 2 da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) Al Kuback M. D.  
8/22, 1929 (Address) 5608 Arsenal

\*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 Union Burial DATE OF BURIAL Aug 23 1929

20. UNDERTAKER\* Wellman & Co., 702 Grand  
ADDRESS

WRITE PAINLY, 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.

