

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

Do not use this space.

29739

1. PLACE OF DEATH

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

Registration District No. **791**
Primary Registration District No. **1003**
City Sanitarium

File No.....
Registered No. **9613**
St..... Ward.....

2. FULL NAME

(a) Residence No. *5800 Arsenal* St. *13* 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 *Male* 4. COLOR OR RACE *Black* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 1864*

| AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|-----------|-------|----------------|------|----------------------------------|
| <i>65</i> | | <i>Unknown</i> | | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Laborer*
(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) *Senneville*

10. NAME OF FATHER

Max Daily

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Senneville*

12. MAIDEN NAME OF MOTHER

Ellen Gray

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Senneville*

14.

INFORMANT *Mrs. Eugenie*
(Address) *5800 Arsenal St St Louis*

15.

FILED *Nov 2 1929* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8-31* 19*29*

17. I HEREBY CERTIFY, That I attended deceased from *Dec 22* 19*27* to *Aug 31* 19*29* that I last saw him alive on *8-31* 19*29*, and that death occurred, on the date stated above, at *12:35* 19*29* p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.
None
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS? *Physical Examination*

(Signed) *D. Staley* M. D.

9-1 19*29* (Address) *5800 Arsenal St.*

*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

St. Louis 4.

9-5 19*29*

20. UNDERTAKER

ADDRESS

Walter Richter

3500 Rutgerst

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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