

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

Do not use this space.

32012

1. PLACE OF DEATH

County..... Registration District No.....

Township..... Primary Registration District No.....

City..... *St. Louis, Mo.* City Hospital #2..... St..... (Ward)

File No.....

Registered No. *9042*

2. FULL NAME

(a) Residence. No. *3122 Pine* 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 *14* 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 *col.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *3-4-1879*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
50 5 29

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) *Penn.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Mance Randles*

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

12. MAIDEN NAME OF MOTHER *Easter Wooden*

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

14. INFORMANT *U. H. Temple's Death*
(Address) *City Hospital #2*

15. SEP 7 1929
FILED 19 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9-3-1929*

17. I HEREBY CERTIFY, That I attended deceased from *8-24-29*, to *9-3-29*, 19*29* that I last saw him alive on *9-3-29*, 19*29*, and that death occurred, on the date stated above, at *3 AM* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131
93C
Chronic myocarditis
(duration) *6* yrs. *6* mos. *—* ds.
CONTRIBUTORY *Chronic nephritis*
(SECONDARY)
(duration) *10* yrs. *10* mos. *—* ds.

18. WHERE WAS DISEASE CONTACTED *129 W*

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *Chemical*

(Signed) *A. E. Hale*, M. D.

9/3/29, 19*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 *Nashville Tenn* DATE OF BURIAL *Sept 7 1929*

20. UNDERTAKER *J. W. Hughes* ADDRESS *2620 Lawton*

