

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

Do not use this space.

**1. PLACE OF DEATH**

County Cole  
Township St. Louis  
City St. Louis (No. ....)

Registration District No. 9B  
Primary Registration District No. 3014

File No. 33313  
Registered No. 295  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. Destine Clifton Lawson St. .... 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 8 - 1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
51 3 23

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Brickmaker  
(b) General nature of industry, business, or establishment in which employed (or employer) Self  
(c) Name of employer St. Louis

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

(STATE OR COUNTRY)

10. NAME OF FATHER Mr. E. Dawson

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

12. MAIDEN NAME OF MOTHER Anna Roberts

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

14. INFORMANT Mr. B. C. Dawson  
(Address) St. Louis Road

15. FILED ..... 19 ..... REGISTRAR

**✓ MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 31 29

17. HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Oct 31, 1929, that I last saw him alive on Oct 31, 1929, and that death occurred, on the date stated above, at 9:45 P.M.

(THE CAUSE OF DEATH WAS AS FOLLOWS:

Cerebral hemorrhage  
82A  
82D

CONTRIBUTORY The first hemorrhage  
(SECONDARY) with paralysis 4 yrs ago  
(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF ✓

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) W. A. Clark, M. D.

1177, 1929 (Address) Jaffrey Avenue

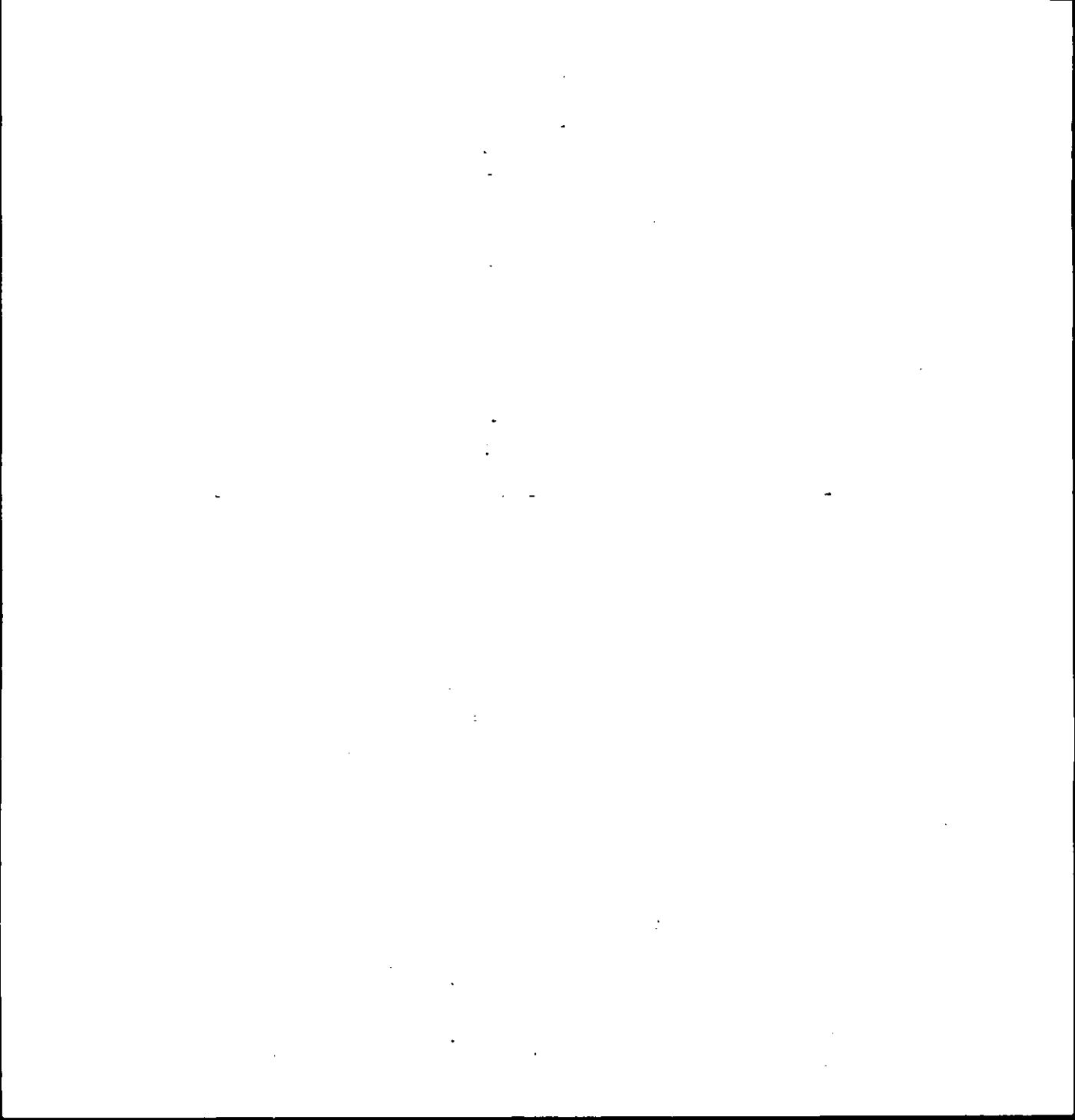
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER Lawson

ADDRESS St. Louis



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Cole

Registration District No. 213

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 3014

Registered No. 233-

City Jeff City

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

14. INFORMANT \_\_\_\_\_ (Address) \_\_\_\_\_

15. FILED 11-5-29 L. S. B. J. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 31 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

\_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY)

\_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19 \_\_\_\_\_ (Address) \_\_\_\_\_

\*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

19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-33313