

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

Do not use this space.

35102

791

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No.....
Primary Registration District No. 1005
(No. Mo Pacific Hospital.)

File No.....
Registered No. 9823
St. Ward)

2. FULL NAME

Albert Atkins

(a) Residence. No. 7101 Virginia St., 1 Ward.

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. (If nonresident, give city or town and State)

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) June 18 - 1895

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. min.
	<u>34</u>	<u>3</u>	<u>15</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Passing Watches
(b) General nature of industry, business, or establishment in which employed (or employer) R R
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Andrew Atkins

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

12. MAIDEN NAME OF MOTHER Ellen Healy

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

14. INFORMANT Andrew Atkins

(Address) 7101 Virginia

15. FILED Oct - 5 1920 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 3 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1929 and that I last saw him live on Oct 3 1929 and that death occurred, on the date stated above, at Oct 3 - 21 6 AM

46B THE CAUSE OF DEATH* WAS AS FOLLOWS:
Basal carcinoma of Stomach

Myocarditis Chronic (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Myocarditis Chronic (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED undetermined

IF NOT AT PLACE OF DEATH Mo. Pac. Hospital

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF 9/16/29

WHAT TEST CONFIRMED DIAGNOSIS X-ray, Biopsy, Operation

(Signed) Marvin Reichman M. D.

19 (Address) Mo. Pac. Hospital City

*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

Lee Soto Mo 10-7 1929

20. UNDERTAKER ADDRESS 7315

Southern 13day

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.

WRITE IN PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD

