

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

Do not use this space.

35371

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... **St. Louis** Primary Registration District No. **1003**
 City..... **St. Louis** (No. **Foot Arsenal St**)

File No.
 Registered No. **10114** ..
 St. Ward

2. FULL NAME **Harry Nesbitt**

(a) Residence. No. **2nd Arsenal St.** St. **24** 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 Unknown	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/> <input checked="" type="checkbox"/>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown					
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.	
Alt	45	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work..... Water					
(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) Unknown					
PARENTS	10. NAME OF FATHER				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown				
	12. MAIDEN NAME OF MOTHER Unknown				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)				

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **10/8/29** 19..

17. I HEREBY CERTIFY, That I attended deceased from.....
, 19..... to....., 19.....
 that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... **2:15 a.m.**

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Asphyxiation (Due to drowning)

Whether accidental or intentional was not ascertained (duration)..... yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... **NO** DATE OF.....
WAS THERE AN AUTOPSY?..... **NO**

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **Wm V Dwyer** M.D.
10/15, 19**29** (Address) **Coroner**

*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 **St. Matthews** **DATE OF BURIAL** **10/15** 19**29**

20. UNDERTAKER **Ziegler** **ADDRESS** **2621 Cherokee**

14. INFORMANT **J. W. Corver**
 (Address) **Coroner's Office**

15. OCT 15 1929 **FILED** **19** **REGISTRAR**

WRITE PLAINLY, WITH UNWADING 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.

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