

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

Do not use this space.

35166

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *St. Louis, Mo.* (No. *2749th Market St.*)

File No.....
Registered No. **10212**
St. Ward)

2. FULL NAME

(a) Residence. No. *2749th Market* St., *25* 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. *1* 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) *infant*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 16, 1929*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, *12* hrs. or *0* min.
0 *0* *0*

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *St. Louis, Mo.*
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER *Johnnie Hawkins*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Greenwood Miss.*
12. MAIDEN NAME OF MOTHER *Eugenia Wilson*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Pittsburg Kansas*

14. INFORMANT *Johnnie Hawkins*
(Address) *2749th Market Ave.*

15. FILED *Oct 18 1929* *Max C. Stankoff* REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from *Oct 16* 1929 to *Oct 16* 1929 that I last saw him alive on *Oct 16* 1929 and that death occurred, on the date stated above, at *3* p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
159
10161
gophytia (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *fluids* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH *not*

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF *no*
WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS *clinical*
(Signed) *H. A. Cull* M. D.
, 19 (Address) *450. Court 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 *Washington Pk.* DATE OF BURIAL *10-18-1929*

20. UNDERTAKER *Peoples Ind. Co.* ADDRESS *Franklin*

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.

WHILE IN PRINT, WITH CHANGING INK—THIS IS A PERMANENT RECORD

