

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

Do not use this space.

35663

1. PLACE OF DEATH

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

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **10453**
St. Ward)

2. FULL NAME

(a) Residence. No. **4914 Arzyle** St. **12** 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 **Barbara Andrews**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 24 1859**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	69	11	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. **Mill Owner**
(b) General nature of industry, business, or establishment in which employed (or employer). **Flour mills**
(c) Name of employer

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

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Annie Lee**

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

14. INFORMANT **Barbara Andrews**
(Address) **4914 Arzyle**

15. FILED **Oct 24 1929** **Walter E. Stark** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct. 23rd 1929**

17. I HEREBY CERTIFY, That I attended deceased from **Oct. 17**, 19**29**, to **Oct 23**, 19**29** that I last saw him alive on **Oct 22**, 19**29**, and that death occurred, on the date stated above, at **1 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
with Pleurisy
108 (duration) yrs. mos. **6** ds.

CONTRIBUTORY **arterial sclerosis**
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? **NOT AT PLACE OF BIRTH**

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **D.R. Parman**, M. D.
, 19 (Address) **503 Wall Bldg St Louis,**

*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 **Oct 25 1929**

20. UNDERTAKER **Philander Craig Washington** ADDRESS **468**

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 CARE.

