

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

Do not use this space.
35789
File No. _____
Registered No. **10590**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis** (No. **City Hospital**)
11596

2. FULL NAME

John Stevens
(a) Residence, No. **2274 Blenden Place** 4. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred **25** 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 **married**
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July-29-1870**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	59	2	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Carpenter**
(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) **Ohio**

10. NAME OF FATHER **William Stevens**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Ohio**

12. MAIDEN NAME OF MOTHER **Laura Fread**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Ohio**

14. Hospital Information

INFORMANT **Dr. Johnson**
(Address) **City Hospital**

15. FILED **28 1929** REGISTRAR **W. H. Starnes**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct. 27 1929**

17. I HEREBY CERTIFY, That I attended deceased from **Oct. 25**, 19**29**, to **Oct. 27**, 19**29** that I last saw him alive on **Oct. 27**, 19**29**, and that death occurred, on the date stated above, at **3.10 a. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of the lung.
2 yr
0.926

(duration) _____ yrs. mos. ds.
CONTRIBUTORY **Chronic myocarditis**
(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) **John Starnes**, M. D.

1428, 1929 (Address) **City Hospital**

*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

Valhalla Cem

10-29 1929

20. UNDERTAKER

ADDRESS

Kreighbaumier and Co
4225 S. Highway

WRITE PLAINLY, WITH UNFADING 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.

Handwritten signature