

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

Do not use this space.

**1. PLACE OF DEATH**

County St. Louis  
Township North  
City St. Louis (No. \_\_\_\_\_)

Registration District No. 846  
Primary Registration District No. \_\_\_\_\_

File No. 36063  
Registered No. 26  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) D

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 21 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
68 2 2

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Ill

(STATE OR COUNTRY)

10. NAME OF FATHER V

11. BIRTHPLACE OF FATHER (CITY OR TOWN) V

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER V

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) V

(STATE OR COUNTRY)

14. INFORMANT Lee Brakeman  
(Address) Miller Neb

15. FILED 1028, 1929 H. A. Simon  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-28 29

17. I HEREBY CERTIFY, That I attended deceased from Oct-20 to Oct-25 1929  
that I last saw him alive on Oct-25 1929, and that death occurred, on the date stated above, at 5 PM.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Bronchitis Pneumonia

107M (duration) yrs. mos. 4 ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? Yes DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Chemical

(Signed) H. L. Reynolds, M. D.

Oct-24-1929 (Address) Crane Neb

\*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

Ansley Neb

10 26 1929

20. UNDERTAKER W. H. Nelson

ADDRESS Crane Neb

AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH should be stated in terms, so that it may be properly classified.

FOR THE

SECRET

1. The following information is being furnished to you for your information only. It is not to be used for any other purpose.

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Stone  
Township Quincy  
City Quincy (No. ....)

Registration District No. 846  
Primary Registration District No. 6283

File No. ....  
Registered No. 26  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... St. .... 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) ill

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

**8. OCCUPATION OF DECEASED**

- (a) Trade, profession, or particular kind of work  
(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)

10. NAME OF FATHER unknown

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) unknown

14.

INFORMANT (Address)

15.

FILED 10-28-29

H. A. Shuman  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 23 29

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw him alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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) ....., M. D.  
, 19 (Address)

\*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 |
| 20. UNDERTAKER                             | ADDRESS        |

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.

REGISTRARS SHALL GIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-36063