

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

Do not use this space.

37092

1. PLACE OF DEATH

County Jackson
Township Franklin
City St. Louis (No. 1249 Pennsylvania)

Registration District No. 399
Primary Registration District No. 1092

File No. _____
Registered No. 4559
St. _____ Ward _____

2. FULL NAME

William McDonald Jr

(a) Residence. No. 1249 Pennsylvania 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 Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unk 1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Paperhanger
(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) Miss

10. NAME OF FATHER Wm McDonald

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

12. MAIDEN NAME OF MOTHER Wickerson

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

14. INFORMANT Mrs Hattie McDonald
(Address) 1249 Pennsylvania

15. FILED 11/5 29 19 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-4-1929

17. I HEREBY CERTIFY, That I attended deceased from 11-20-1929, to 11-4-1929, that I last saw h. alive on 11-4-1929, and that death occurred, on the date stated above, at 6:00 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
9.3-1929
Acute Pulmonary Tuberculosis

(duration) yrs. mos. ds. _____

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

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH untown

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS Labatory

(Signed) J. S. Wells, M. D.
"15, 1929 (Address) 1433 E 18th Kcmo.

*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 Blue Ridge Lawn DATE OF BURIAL 11-5-1929

20. UNDERTAKER W. H. Moore ADDRESS 1820 E 18.

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.

71
2

18th of Passo.
