

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

Do not use this space.

39004

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis, Mo. (No. City Ward # 2) St. Ward)

File No.
 Registered No. 11481

2. FULL NAME

Demie Patterson
 (a) Residence. No. 2736^a Walnut St., 2^h 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 <u>Male</u>	4. COLOR OR RACE <u>Cal</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <u>Annie Patterson</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>11-10-1900</u>		
7. AGE	YEARS	MONTHS
	<u>29</u>	
		DAYS
		<u>5</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work. <u>Janitor</u>		
(b) General nature of industry, business, or establishment in which employed (or employer).....		
(c) Name of employer.....		
9. BIRTHPLACE (CITY OR TOWN) <u>Holly Grove Ark</u> (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER <u>Not Known</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>not known</u> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <u>not known</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>not known</u> (STATE OR COUNTRY)	

14. INFORMANT Annie Patterson
 (Address) 2736^a Walnut St

15. FILED NOV 21 1929 Chas. O. Starkey
 19..... REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/15 1929

17. No (Physician in attendance) I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., and that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... 11:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
930
 (duration)..... yrs..... mos..... ds.

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

18. WHERE WAS DISEASE CONTRACTED.....
 IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. W. Keener, M.D.
11/19/29 (Address) Dep. Comm

*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 Park DATE OF BURIAL 11-24 1929

20. UNDERTAKER A. J. Bed and Co. ADDRESS 2726 Subst. Ark.

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.

