

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

Do not use this space.

39206

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 10003
City..... St. Louis (No. 3933) Kennemurly av

File No.....
Registered No. 11691
St..... Ward)

2. FULL NAME

Jamer H Hyde
(a) Residence No. St., 11 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>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Sarah Hyde</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec 29, 1856</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>72</u>	<u>10</u>	<u>0</u>	

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

9. BIRTHPLACE (CITY OR TOWN)..... Washington
(STATE OR COUNTRY)..... D. C.

10. NAME OF FATHER..... Jamer Hyde

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

12. MAIDEN NAME OF MOTHER..... Margaret M. Hamara

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

14. INFORMANT..... Josephine Hyde
(Address)..... 3933 Kennemurly av

15. FILED..... Nov 50
REGISTRAR..... Max C. Starnes

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-29 1929

17. I HEREBY CERTIFY, That I attended deceased from last 1929 to Nov-22, 1928
that I last saw him alive on 11/23— 1928 and that death occurred, on the date stated above, at 5 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
lethargic myocarditis
930
1929
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)..... Arterio Sclerosis
Senesal (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? NO DATE OF.....
WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed)..... W. B. Gessert M. D.
11/30, 1929 (Address) 4500 Olive St

*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..... Calvary DATE OF BURIAL..... 12-2, 1929

20. UNDERTAKER..... Arthur J. Donnelly ADDRESS..... 2039 1/2 Oak St

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 PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

23
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For C. W. Cassatt

Letter Book