

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City St. Louis (No. ....)

Registration District No. 791  
Primary Registration District No. 1003  
Alexander Bros. Bldg.

File No. 39239  
Registered No. 11731  
Ward) .....

**2. FULL NAME**

(a) Residence. No. Joe Lamb St. 14 Ward. Gillespie Ill  
(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>Unknown Widowed</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown</u>		
7. AGE <u>about 58</u>	YEARS	MONTHS
		DAYS
		If LESS than 1 day, ..... hrs. or ..... min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Miner</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Coal</u> (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>England</u>		
PARENTS	10. NAME OF FATHER <u>Unknown</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
14. INFORMANT <u>L. Ann Burchie</u> (Address) <u>Gillespie Ill</u>		
15. FILED <u>LEC -2, 1929</u> <u>May C. Starkey</u> 19..... REGISTRAR		

**MEDICAL CERTIFICATE OF DEATH**

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 30 1929

17. 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..... 8 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Polar Pneumonia  
108  
117A (duration) ..... yrs. .... mos. .... ds.

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

18. WHERE WAS DISEASE CONTRACTED 1010  
IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH? ..... DATE OF.....  
WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) J. W. Kesner, M.D.  
152, 1929 (Address) By. Coroner

\*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 <u>Gillespie Ill</u>	DATE OF BURIAL <u>Dec 3 1929</u>
20. UNDERTAKER <u>Union Funeral Assn.</u>	ADDRESS <u>Gillespie Ill</u>

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.

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8  
31

JLL

