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

Do not use this space.

39302

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 12763

City St. Louis (No. City Hospital St. ..... Ward)

2. FULL NAME 13 Jan 75 John Heath

(a) Residence. No. City Hospital St., 23 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 16 - 1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	70	9	13	

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

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9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Pennsylvania

2

PARENTS

10. NAME OF FATHER David Heath
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Pennsylvania
12. MAIDEN NAME OF MOTHER Crown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Pennsylvania

14. INFORMANT Hospital Incomplete
(Address) City Hospital

15. FILED DEC 30 1929 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1929 to Nov 29, 1929 that I last saw him alive on Nov 29, 1929 and that death occurred, on the date stated above, at 11 40 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Strangulated Inguinal
Hernia Right
Chr. Myocarditis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Senility
(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? Clinical

(Signed) Edward Hellwig, M. D.
11/30, 1929 (Address) City Hospital

*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
Washington	12/13 1929
20. UNDERTAKER	ADDRESS
W. Richter 3500	Rutger St.

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.

Health