

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

Do not use this space.

39376

File No. 6  
Registered No. 1125  
St. 0 Ward

**1. PLACE OF DEATH**

County St. Louis Registration District No. 1177  
Township Blanc Creek Primary Registration District No. C.O. 99  
City 0 (No. 0)

**2. FULL NAME**

Pallas Nat  
(a) Residence, No. 0 St. 0 Ward. (If nonresident, give city or town and State)  
(Usual place of abode)  
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>M</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE <u>84</u> YEARS	MONTHS	<u>11</u> DAYS	If LESS than 1 day, ..... hrs. or ..... min.
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**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House Keeper  
(b) General nature of industry, business, or establishment in which employed (or employer) 0  
(c) Name of employer 0

9. BIRTHPLACE (CITY OR TOWN) Raymond County Mo  
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Cass Warren  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Mrs. Keel  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo  
(STATE OR COUNTRY)

14. INFORMANT 0  
(Address)

15. FILED Nov 3, 1929 Lucy Jackson  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

2008  
..... (duration) ..... yrs. .... mos. .... ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY? .....  
WHAT TEST CONFIRMED DIAGNOSIS? .....  
(Signed)....., M. D.  
. 19 (Address)

\*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>Knuckles cemetery</u>	DATE OF BURIAL <u>Nov 7 1929</u>
20. UNDERTAKER	ADDRESS

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.

