

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

Do not use this space.

42121

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 7003

City St. Louis (No. City Hospital #2)

File No.

Registered No. 11825

St. Ward)

2. FULL NAME

(a) Residence. No. 2707 Easton St. 21 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

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 6 - 1897

7. AGE

YEARS
32

MONTHS
1

DAY
26

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ferguson

(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Martin Griffin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Winchell

(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Hattie Wheeler

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ferguson

(STATE OR COUNTRY) Mo.

14.

INFORMANT Hattie Griffin

(Address) Ferguson Mo.

15.

FILED DEC - 4 1929

19

REGISTRAR May C. Barker

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 2 19 29

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..... 6:55 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) None

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

20. WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Kerne, M.D.

12/3 1929 (Address) Dep. 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

Washington Park

DATE OF BURIAL

12/6 19 29

20. UNDERTAKER

Manuel Indutsky Co.

ADDRESS

2707 Easton St. Ferguson

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.

