

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

Do not use this space.

42211

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1803  
 City St. Louis (No. Forest Post Jeff. Memorial Ward)

**2. FULL NAME**

(a) Residence. No. 5703 Clemens St., 5 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 2 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
66 10 3

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

9. BIRTHPLACE (CITY OR TOWN) Baltimore  
 (STATE OR COUNTRY) Maryland

10. NAME OF FATHER John P. Nath

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

12. MAIDEN NAME OF MOTHER Not ascertainable

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

14. INFORMANT Katie Nath  
 (Address) 5703 Clemens

15. FILED LEG - 1 1929 Max C. Tucker  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 5 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 10:10 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: Gun Shot Wound  
Head

Self Inflicted yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED 170  
 IF NOT AT PLACE OF DEATH.....

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

20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS  
 (Signed) J. W. Kerne, M.D.

(Address) Dep. Coroner  
1277, 1929

\*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 Cemetery DATE OF BURIAL Dec 9 1929

20. UNDERTAKER Harrigan & Sheahan & Co ADDRESS Washington

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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