

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

Do not use this space.

42890
12686

1. PLACE OF DEATH

County Registration District No. 701
 Townshp. St. Louis Mo. City Hospital Primary Registration District No. 1003 File No. 42890
 City St. Louis Mo. City Hospital Registered No. 12686 St. 2 Ward 2

2. FULL NAME

(a) Residence. No. Anglem, Mo St. 23 Ward. Anglem Sec -
 (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 Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-15-1877

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	52	3	13	

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

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

10. NAME OF FATHER Daniel Webster

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

12. MAIDEN NAME OF MOTHER Melinda (unknown)

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

14. INFORMANT A. Gertrude Creath
 (Address) City Hospital

15. FILED DEC. 29, 1929 Wm C. Fisher REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-28 1929

17. I HEREBY CERTIFY, That I attended deceased from 12-24, 1929, to 12-28, 1929 that I last saw him alive on 12-27, 1929 and that death occurred, on the date stated above, at 3:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: 3 1/2

The Myocarditis
12 1/2 (duration) yrs. 6 mos. ds.
 CONTRIBUTORY The Nephritis
 (SECONDARY) (duration) yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home
 *IF NOT AT PLACE OF DEATH.
 DID AN OPERATION PRECEDE DEATH? no DATE OF
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Urinalysis
 (Signed) H. H. Leathers, M. D.
1/28, 1929 (Address) City Hospital #2

*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 Greenwood DATE OF BURIAL 1-1-1930

20. UNDERTAKER D. S. Wade ADDRESS 4202

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.

