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

Do not use this space.

2583

File No.

Registered No. 11

1. PLACE OF DEATH

County St Louis County — Registration District No. 1123

Township CAROLINA — Primary Registration District No. 6248 E

City St Louis Mo (No. Mt. St. Rose St. Ward)

2. FULL NAME Howard Herndon

(a) Residence. No. Fayette, Mo St., 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. 45 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) Febr. 5 1908

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
19		11	11	

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

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

PARENTS

10. NAME OF FATHER John N. Herndon

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

12. MAIDEN NAME OF MOTHER Nellie Howard

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

14. INFORMANT Mount St Rose Record
(Address) 9101 S Broadway

15. FILED Jan 7 1930 L. C. Obrock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-16-30 19

17. I HEREBY CERTIFY, That I attended deceased from 11-4-29, 19, to 1-16-30, 19 that I last saw him alive on 5 P.M. 1-16, 1930, and that death occurred, on the date stated above, at 5:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

23A
110B PULMONARY T. B

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (SECONDARY) Spontaneous pneumothorax

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Contracted at home
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. D. Crecelius, M. D.
, 19 (Address) 9101 So Broadway

*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
New Franklin Mo	1-20 1930
20. UNDERTAKER	ADDRESS 6320
Southern	S. Grand Blvd

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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