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

Do not use this space.

6371

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. 7108 St James Sq St. ..... Ward)

File No. .....

Registered No. 1140

2. FULL NAME John Walter Mann

(a) Residence. No. 7108 St James Sq St., 4 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 M

4. COLOR OR RACE W.

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 10 1929

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
=	5	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Walter Mann

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

12. MAIDEN NAME OF MOTHER Celeste M Prosser

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

14. INFORMANT Walter Mann
(Address) 7108 St James Sq

15. FILED FEB 23 1931 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 1, 1930

17. No Physician in attendance
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 9 00 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastro-Enteritis
119B

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

CONTRIBUTORY (SECONDARY) 113B

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

18. WHERE WAS DISEASE CONTRACTED

8 IF NOT AT PLACE OF DEATH .....

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? [signature]

(Signed) [signature], M.D.

2/3, 1931 (Address) Deputy 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 Calvary Cem

DATE OF BURIAL 2/3/30 19

20. UNDERTAKER Coghlan - 7146 Manchester

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.