

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

Do not use this space.

6617

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis, Mo.* (No.)

Registration District No. *701*
Primary Registration District No. *1000*

File No.....
Registered No. *1434*
St. Ward)

2. FULL NAME

Andrew Case

(a) Residence. No. *3650 Shewardale* St. *13* Ward.

Length of residence in city or town where death occurred *68* yrs. *4* mos. *21* 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) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept. 19 - 1861*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>68</i>	<i>4</i>	<i>20</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Post Office Clerk*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer *U.S. Government*

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

10. NAME OF FATHER *Unknown*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Missouri*
12. MAIDEN NAME OF MOTHER *Unknown*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St. Louis*
(STATE OR COUNTRY) *Missouri*

14. INFORMANT *W.R. Summers*
(Address) *5300 Grand St. Kansas*

15. FILED *Jan 20 1919* REGISTRAR *W. Stanley*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb. 9th 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Sept. 17th 1928*, to *Feb. 9th 1930*, that I last saw him alive on *Feb. 8th 1930*, and that death occurred, on the date stated above, at *9:45 A.M.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

Bronchopneumonia
1094
160 (duration) yrs. mos. *5* ds.

CONTRIBUTORY (SECONDARY) *Senile Psychosis*
(duration) *1* yrs. *4* mos. *23* ds.

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

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *W.R. Summers* M. D.

7/9, 1930 (Address) *5300 Grand*
*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 *Zions* DATE OF BURIAL *Feb 11 1930*

20. UNDERTAKER *Ziegenhain Box 2623 Cherokee*
ADDRESS

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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