

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

Do not use this space.

6688

1. PLACE OF DEATH

County.....

Registration District No.....

791

1003

Township.....

Primary Registration District No.....

City.....

St. Louis (No. No. Baptist Cemetery)

File No.....

1511

Registered No.....

St.....

Ward.....

2. FULL NAME

(a) Residence. No. *4133 Cleveland* St., *17* 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)

Single

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

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

not known

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

abt 50

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

night watchman

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

(c) Name of employer

Burkhat mfg Co

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Co. Mex. Mex. Ireland

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ireland

14.

INFORMANT.....

(Address) *Don J. Murphy*

4133 Cleveland av

15.

FILED.....

19.....

May C. Starkey

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 11* 19*30*

17.

HEREBY CERTIFY, That I attended deceased from *Oct 1*, 19*28*, to *Feb 11*, 19*30* that I last saw him alive on *Feb 10*, 1930, and that death occurred, on the date stated above, at *10:30* a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Myocarditis
Auricular fibrillation
93C
95A (duration) *5* yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

None

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Physical Exam*

(Signed) *Samuel B. Grant*, M. D.

Feb 11, 1930 (Address) *3720 Washington*

*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

Calloway Cem

Feb 14 1930

20. UNDERTAKER

ADDRESS

Mrs J. Finan

1519 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.

15
192

W. B. Grant