

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

Do not use this space.

6784

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

St. Louis mo. (No. City Hospital #2)

File No.

Registered No. **1619**

St. Ward)

2. FULL NAME

(a) Residence. No. **3819 FINNEY AVE.** Ward **11**
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **1/6** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **col.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **married**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2-12-30**

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

17. I HEREBY CERTIFY, That I attended deceased from **12-11-29** to **2-12-30**, 19**30** that I last saw h. **l.** alive on **2-12-30**, and that death occurred, on the date stated above, at **9.25** a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: **9.25 P.M.**

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin. **abh 37** — —

Chronic myocarditis
936 (duration) **9** yrs. mos. ds.

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

CONTRIBUTORY (SECONDARY) **9015** (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) **Ky.** (STATE OR COUNTRY)

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

10. NAME OF FATHER **Ed Bruin**

18. DID AN OPERATION PRECEDE DEATH? **NO** DATE OF **—**

18. WAS THERE AN AUTOPSY? **NO**

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

18. WHAT TEST CONFIRMED DIAGNOSIS **Clinical** (Signed) **A. E. Hale**, M. D.

12. MAIDEN NAME OF MOTHER **unknown**

18. (Address) **2/13/30 City Hosp. #2**

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

*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.

14. INFORMANT **A. Gertrude Creath** (Address) **City Hospital #2**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Hopkinsville Ky** DATE OF BURIAL **2/16 1930**

15. FILED **FEB 15 1930** **Max C. Starnes** REGISTRAR

20. UNDERTAKER **A. Russell Lind** ADDRESS **2732 Pine**

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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