

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

Do not use this space.

7021

1. PLACE OF DEATH

County.....
Township *St. Louis, Mo.*
City *St. Louis, Mo.*

Registration District No. *791*
Primary Registration District No. *1003*
City Hospital #2

File No. *1887*
Registered No.
St. Ward)

2. FULL NAME

(a) Residence No. *924(A) N. 2nd St.* Ward. *21*

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>male</i>	4. COLOR OR RACE <i>col.</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>1-11-1861</i>		
7. AGE YEARS <i>68</i>	MONTHS <i>3</i>	DAYS <i>10</i>
		If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer) *Lab - Odd jobs*

(c) Name of employer

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

10. NAME OF FATHER *John Humphrey*

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

12. MAIDEN NAME OF MOTHER *Laura W. ...*

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

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

15. FILED *1930* REGISTRAR *Ray C. Starker*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2/21/1930*

17. I HEREBY CERTIFY, That I attended deceased from *2-20-1930* to *2-21-1930* that I last saw him alive on *2-21-1930* and that death occurred, on the date stated above, at *4:15 am.*

18. THE CAUSE OF DEATH* WAS AS FOLLOWS: *Chronic myocarditis*
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Chronic nephritis*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? *1290*

IF NOT A PLACE OF DEATH

DID AN EPIDEMIC PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Autopsy*
(Signed) *A. E. Hale* M. D.

(Address) *2945 Lawton Av.*

*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 *C. Thomas Lee* DATE OF BURIAL *Feb 23 1930*

20. UNDERTAKER *J. Marshall* ADDRESS *P. O. Lee*

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.

31-1-237

