

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

Do not use this space.

7024

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No. *2803 Stoddard*)

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **1890**
St. Ward.....

2. FULL NAME

Jaron Kendrick
(a) Residence. No. *2803 Stoddard* St. *21* 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 *Negro* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *unk. abt. 1878*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>About 52</i>	<i>✓</i>	<i>✓</i>	<i>✓</i>	

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)..... *Old jobs*
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *unknown*

10. NAME OF FATHER.....

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

12. MAIDEN NAME OF MOTHER.....

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

14. INFORMANT: *Mary Kendrick*
(Address) *2803 Stoddard*

15. FILED..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 12 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 10 1930* that I last saw him alive on *Feb 10 1930* and that death occurred, on the date stated above, at *11:17 AM*

THE CAUSE OF DEATH WAS AS FOLLOWS:

Robert Pneumonia

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) *E. J. Stewart* M. D.

2-20-30 (Address) *11 N. Jefferson*

*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 *Washington Park Cemetery* DATE OF BURIAL *2/24 1930*

20. UNDERTAKER *Gates' Funeral Home* ADDRESS *4107 Linney*

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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