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

Do not use this space.

File No. 7169
Registered No. 2042

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1002

City St. Louis Mo (No. City Infirmary St. ..... Ward)

2. FULL NAME George Remmington

(a) Residence. No. 5800 - Arsenal St., 13 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. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M.	W.	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 6th 1853

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, ...hrs. or ....min.
76	5	19	

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

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

PARENTS
10. NAME OF FATHER James Remmington
11. BIRTHPLACE OF FATHER (CITY OR TOWN) England
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Grace Hemmingway
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) England
(STATE OR COUNTRY)

14. INFORMANT Mrs. Effinger
(Address) 5800 Arsenal St.

15. FILED ....., 19 .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-25 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-4, 1930, to 2-25, 1930, that I last saw him alive on 2-21, 1930, and that death occurred, on the date stated above, at 12:45 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
93
97 (duration) ? yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Arteriosclerosis
(duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) [illegible] M. D.
2-26, 1930 (Address) 5600 Arsenal

*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 Zion Cemetery
DATE OF BURIAL 2-26 1930

20. UNDERTAKER McLaughlin
ADDRESS 1631 Mo ave

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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