

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

Do not use this space.
7301
File No. _____
Registered No. **2212**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis, Mo.** (No. **City Hospital # 2**)

2. FULL NAME

Willie Degendon
(a) Residence. No. **2708 Lucas** 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 **Life** mos. ds. How long in U.S., if of foreign birth? yrs. moa. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male	4. COLOR OR RACE col.	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) 2-3-29				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	1	-	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **nil**
(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 John Herndon
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Miss (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Fizzie Allen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Miss (STATE OR COUNTRY)

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

15. FILED **127** 19 **30**
W. H. H. H. H. REGISTAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2/27/1930**
17. I HEREBY CERTIFY That I attended deceased from **2-20-1929** to **2-27-1930** that I last saw him alive on **2-27-1930** and that death occurred, on the date stated above, at **10:40 am**.
THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumococci meningitis
lobar (Pneumonia) (duration) _____ yrs. _____ mos. **4** ds.
(SECONDARY) (duration) _____ yrs. _____ mos. **6** ds.

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 **clinical**
(Signed) **A. H. H. H.** M. D.
2/28/1930 (Address) **City Hospital # 2**

*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 **City Hospital # 2** DATE OF BURIAL **3/4 1930**

20. UNDERTAKER **E. W. Reynolds** ADDRESS **3015 7th**

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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