

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

Do not use this space.

7311

1. PLACE OF DEATH

County.....

Registration District No.....

791
1003

Township.....

Primary Registration District No.....

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

File No.....

Registered No. *2434*

St..... Ward)

2. FULL NAME

(a) Residence. No. *15157 Pappin* St., *22* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *9* 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>married</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *-*

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

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day,hrs. ormin.
<i>abt. 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). *Unknown*

(c) Name of employer. *Unknown*

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

PARENTS

10. NAME OF FATHER *Oba Pappin*

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

12. MAIDEN NAME OF MOTHER *Katie Henderson*

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

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

15. FILED..... 19 *Mar 2* *Starkley*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2-28-1930*

17. I HEREBY CERTIFY, That I attended deceased from *2-18-1930* to *2-28-1930*, and that I last saw him alive on *2-28-1930*, and that death occurred, on the date stated above, at *7:15 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of Stomach

CONTRIBUTORY (SECONDARY) *440* (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*

(Signed) *A. E. Hale*, M. D.

3/1/30 (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 HOMICIDE.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Greenwood Cemetery *March 30 1930*

20. UNDERTAKER

ADDRESS *3111*

J. C. Thomas *Ladue*

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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