

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

Do not use this space.

10262

1. PLACE OF DEATH

County..... Registration District No. 751
Township..... Primary Registration District No. 1000
City St. Louis Mo (No. Christian Deep)

File No.
Registered No. 2227
St. Ward)

2. FULL NAME

(a) Residence. No. 1587 1/2 Plymouth St., 5 Ward.

(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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 10 - 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 7 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Machinist
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Michigan

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Lavinia Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT L. May Chapman
(Address) 587 1/2 Plymouth

15. FILED W. A. Starnitz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1929, to Mar 2 1930 that I last saw h. Mar 2 1930, and that death occurred, on the date stated above, at 10:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile Dementia

(duration) 1 yrs. 11 mos. 11 ds.
CONTRIBUTORY (SECONDARY) Anemia + Arterio Sclerosis
(duration) 4 yrs. 4 mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Lab
(Signed) F. E. Keeser M. D.

3-3 1930 (Address) 3945 N 112nd

*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 Valhalla Cemetery DATE OF BURIAL March 5 1930

20. UNDERTAKER Sharkey Funeral Home ADDRESS 4355 Washington St.

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.

