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

Do not use this space.
10884

**1. PLACE OF DEATH**

County..... Registration District No. 701

Township..... Primary Registration District No. 1003

City St Louis Mo. (No. City Hospital #2 St. ..... Ward)

File No. ..... Registered No. 2911

**2. FULL NAME** Sherman Sykes

(a) Residence. No. 2128 Adams St., 22 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. 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) |
|---|---|---|
| Male | Col. | Single |

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

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

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| abt. | 13 | unknown | | |

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

9. BIRTHPLACE (CITY OR TOWN) Miss
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER John Sykes
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Miss
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Rosa Love
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Miss
(STATE OR COUNTRY)

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

15. FILED ..... 22 1930 ..... 19 ..... May C. Hoffman REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-18-1930

17. I HEREBY CERTIFY, That I attended deceased from 3-18-, 1930, to 3-18-, 1930 that I last saw him alive on 3-18-, 1930 and that death occurred, on the date stated above, at 9 35 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculous Meningitis
21A
29A (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Cervical Adenitis (Tuberculous) (duration) — yrs. 6 mos. — ds.

18. WHERE WAS DISEASE CONTRACTED? —
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) A. E. Hale, M. D.
3/19/, 1930 (Address) City Hosp. #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 | DATE OF BURIAL |
|---|---|
| Washington Park Cemetery | 3-22 1930 |
| **20. UNDERTAKER** | **ADDRESS** |
| Gates Funeral Home | 4107 Finney |

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.

WRITE PLAINLY, WITH STANDING INKLESS INK IS A PERMANENT RECORD

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