

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

Do not use this space.

10935

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis, Mo (No. City Hospital #3)

File No. ....  
Registered No. 2963  
St. .... Ward)

**2. FULL NAME**

Charles Richardson

(a) Residence. No. 317 So. 22<sup>nd</sup> St. 22<sup>nd</sup> Ward.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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. 52 - -

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work coal-yard worker  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

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

**PARENTS**  
10. NAME OF FATHER unknown  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER unknown  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT A. Bertende Breach  
(Address) City Hospital #3

15. FILED 24 1930 Wm C. Parker REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-20-1930

17. I HEREBY CERTIFY, That I attended deceased from 3-17-1930, to 3-20-1930, that I last saw him alive on 3-20-1930, and that death occurred, on the date stated above, at 7:55 Pm.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Lober Pneumonia  
108

CONTRIBUTORY (SECONDARY) NO (duration) yrs. - mos. 5 ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? No DATE OF -

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS X-Ray

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

3/21/1930 (Address) City Hospital #3

\*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**

Father Dickson

DATE OF BURIAL 21 March 30 1930

**20. UNDERTAKER**

Emmet E. Peter

ADDRESS 3080 Bell

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 UNFADING INK—THIS IS A PERMANENT RECORD

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