

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

Do not use this space.

11189

1. PLACE OF DEATH

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

File No.....
Registered No. 3226
St. Ward)

2. FULL NAME

(a) Residence. No. 480 DeBavilere St. #5
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>col.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>-</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>11-4-1872</u>		
7. AGE	YEARS <u>57</u>	MONTHS <u>4</u>
	DAYS <u>21</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Watchman</u> (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)

10. NAME OF FATHER Brick Heard

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

12. MAIDEN NAME OF MOTHER Sarah Anderson

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

14. INFORMANT A. Blanche Creath
(Address) City Hosp. #2

15. FILED 31 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-25-1930

17. I HEREBY CERTIFY that I attended deceased from 3-19-30 to 3-25-30, 1930, that I last saw him alive on 3-25-1930, and that death occurred, on the date stated above, at 6:25 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of Stomach
HCB
(duration) 1 yrs. 6 mos. - ds.

CONTRIBUTORY (SECONDARY) HCB
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? N.O. DATE OF _____

WAS THERE AN AUTOPSY? N.O.

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) A.E. Hale M. D.
3/26/1930 (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 St. Louis DATE OF BURIAL 3/31/30

20. UNDERTAKER W. Richter 3500 Dutcher ADDRESS

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.

RECORD WITH CHANGING INDEX—THIS IS A PERMANENT RECORD

82
2

