

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

Do not use this space.

14119

1. PLACE OF DEATH

County.....

Registration District No. **701**

Township.....

Primary Registration District No. **11008**

City **St Louis** (No. **1548 29**)

City Hospital

File No.

Registered No. **3448**

St. Ward)

2. FULL NAME **George Jack Flowers**

(a) Residence. No. St., Ward.

Length of residence in city or town where death occurred **29** yrs. mos. ds.

(If nonresident, give city or town and State)

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** **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **myrtle Flowers**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 4 - 1901**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
29 2 1

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). **odd jobs**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Missouri**

10. NAME OF FATHER **Joseph Flowers**

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

12. MAIDEN NAME OF MOTHER **Ellice King**

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

14.

INFORMANT **Myrtle Flowers**
(Address) **City Hospital**

15.

FILED - 7 1930 **Myrtle Flowers** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 5 30**

17. I HEREBY CERTIFY, That I attended deceased from **April 4 1930** to **April 5 1930** that I last saw him alive on **April 5 1930**, and that death occurred, on the date stated above, at **10:45 am**

THE CAUSE OF DEATH WAS AS FOLLOWS:
General Paralysis
of the Insane
Quiet (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **76** (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH DATE OF

20. WAS THERE AN AUTOPSY? **Yes**
WHAT TEST CONFIRMED DIAGNOSIS? **Clinical History & Gross pathology**
(Signed) **Carl D. H. H. M. D.**
4/6 1930 (Address) **City Hospital**

*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 **new St Marcus** **DATE OF BURIAL** **4-7 1930**

20. UNDERTAKER **M^e Laughlin** **ADDRESS** **1631 mo. ave**

K. 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 COMPLETELY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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Flowers.