

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

Do not use this space.

14288

1. PLACE OF DEATH

County _____ Registration District No. 791
 Township _____ Primary Registration District No. 7003
 City St. Louis, Mo. (No. City Hospital #2) St. _____ Ward _____

File No. _____
 Registered No. 3627
 St. _____ Ward _____

2. FULL NAME

Will Milton
 (a) Residence. No. #11 So 22nd St., 27 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 22 - 1877
Black Mountain

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 3 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Coal-Hauler
 (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) Tenn.

10. NAME OF FATHER Nelson Milton

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

12. MAIDEN NAME OF MOTHER Emma Jones

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

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

15. FILED 11 1930 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-9-1930

17. I HEREBY CERTIFY, That I attended deceased from 4-5-1930, to 4-9-1930, 1930, and that I last saw h. last alive on 4-9-1930, and that death occurred, on the date stated above, at 1:50 AM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

108 (duration) - yrs. - mos. 8 ds.

CONTRIBUTORY (SECONDARY) 1010 (duration) - yrs. - 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? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) A. G. Hale M. D.

4/9/1930 (Address) City Hospital #2
 *State the DISEASE CAUSING DEATH 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 Cent DATE OF BURIAL 4-9-1930

20. UNDERTAKER Waters and Sons ADDRESS 2769 Chouteau

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.

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10-11-54