

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

14426

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. **791**  
Primary Registration District No. **1003**

File No.....  
Registered No. **3770**  
#2 St. .... Ward

**2. FULL NAME**

(a) Residence. No. **400 N. Levee St.** **75** Ward.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **25** yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **mal** 4. COLOR OR RACE **col.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec. 1, 1880**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**49 4 4**

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

9. BIRTHPLACE (CITY OR TOWN) **Indianapolis**  
(STATE OR COUNTRY) **Ind.**

10. NAME OF FATHER **not known**  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **not known**  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER **not known**  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **not known**  
(STATE OR COUNTRY)

14. INFORMANT **Minnie Lee Barnes**  
(Address) **(daughter) 1448 Wash St**

15. APR 15 1930 FILED **W. C. Starley**  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Apr. 5 1930**

17. **no physician in attendance**  
I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at **9:30 a. m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Chronic Myocarditis**  
**930.**

CONTRIBUTORY (SECONDARY) **900**  
(duration) ..... yrs. .... mos. .... ds.

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

18. DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) **J. W. Ferrer, M.D.**  
**4/8, 1930** (Address) **Def. Coronary**

\*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 **Washington Park** DATE OF BURIAL **4/15 1930**

20. UNDERTAKER **People's Und. Co.** ADDRESS **Franklin Ave.**

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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