

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

Do not use this space.

14620

**1. PLACE OF DEATH**

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

Registration District No. 791  
Primary Registration District No. 1003  
(No. Isolation Hospital)

File No.....  
Registered No. 3995  
St..... Ward.....

**2. FULL NAME**

(a) Residence. No. 2809 Foster St. 21 Ward.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 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 (write the word)**

Separated

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

Augusta Garland  
2983 Park Ave

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

2-21-1864

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

66

2

0

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

Johnson Shoe Co.

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

England

**10. NAME OF FATHER**

Sam Garland

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

England

**12. MAIDEN NAME OF MOTHER**

Hanne Cox

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

England

**14. INFORMANT**

(Address)

J. Schaffer  
5700 Avenue of the Americas  
Brooklyn, N.Y.

**15. FILED**

19 22

Max E. Kraly  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

4-21 19 30

**17.**

I HEREBY CERTIFY, That I attended deceased from

4-2 19 30, to 4-21 19 30

that I last saw him alive on 4-21 19 30 and that death occurred, on the date stated above, at 1:15 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic myocarditis  
SEC

1819

(duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

Angina of left leg following  
myocardial infarction (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

**WHAT TEST CONFIRMED DIAGNOSIS**

(Signed) Walter K. Kuehl, M. D.

4-21, 19 30 (Address) 5800 Avenue

\*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**

DATE OF BURIAL

New St. Marcus Cm April 23, 1930

**20. UNDERTAKER**

ADDRESS

Stein R. R. 2201 So Grand

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.

