

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

Do not use this space.

14768

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1803**

City **St. Louis, Mo.** (No. **City Hospital #2**)

File No.

Registered No. **4177**

St. Ward)

2. FULL NAME

(a) Residence, No. **1444 1/2 Reed Bldg 25** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **18** yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

wid.

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

-

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

Unknown

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

abt. 57

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)

Miss.

10. NAME OF FATHER

Thomas Dozier

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss.

12. MAIDEN NAME OF MOTHER

Millie Babb

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss.

14. INFORMANT

(Address)

A. Gertrude C. Gath, City Hospital #2

15. FILED

25 1930

Max C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4-10-1930**

17. I HEREBY CERTIFY, That I attended deceased from **3-31-1930** to **4-10-1930** that I last saw h. **mother** on **4-10-1930** and that death occurred, on the date stated above, at **11:30 am**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis 93C

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

POB

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS?

Clinical

(Signed) **A. E. Hale** M. D.

4/11/1930 (Address) **City Hosp #2**

*State the DISEASE CAUSING DEATH, or if 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

St. Louis U.

4-14-1930

20. UNDERTAKER

ADDRESS

Walter Richter

3500 Rutquist

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.

