

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

Do not use this space.

14867

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo. (No. City Hospital #2)

File No.....
 Registered No. 4283
 St. Ward)

2. FULL NAME

William Tainer
 (a) Residence. No. 410 N. Levee St. 25 Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred unknown yrs. 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) Single

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. min.
abt. 45(?) unknown

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) Okla.

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT A. M. Creath (Address) City Hospital #2

15. FILED 11 1930 W. C. Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-28-1930

17. I HEREBY CERTIFY, That I attended deceased from 4-26-1930 to 4-28-1930 that I last saw him alive on 4-28-1930 and that death occurred, on the date stated above, at 2:40 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
82H (duration) yrs. - mos. - ds. 2

CONTRIBUTORY (SECONDARY) 740 (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. E. Hale M. D.

4/29/1930 (Address) City Hospital #2

*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 St. Louis Mo. DATE OF BURIAL 4/29 1930

20. UNDERTAKER Walter Richter ADDRESS/ 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.

237
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37

