

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

Do not use this space.

14873

**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. **4289.**  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **2640 Lucas** 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 **about 25** yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Male</b>	4. COLOR OR RACE <b>col.</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>single</b>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **9-9-1879**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<b>50</b>	<b>7</b>	<b>13</b>	

**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) **General Contractor**  
(c) Name of employer **unknown**

9. BIRTHPLACE (CITY OR TOWN) **Little Rock Ark.**  
(STATE OR COUNTRY)

10. NAME OF FATHER **James Hegwood**

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

12. MAIDEN NAME OF MOTHER **Martha Edwards**

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

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

15. FILED **30**, 19**30** **Max C. Starkey**  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4-22-1930**

17. I HEREBY CERTIFY, That I attended deceased from **1-21-1930** to **4-22-1930** that I last saw him alive on **4-22-1930** and that death occurred, on the date stated above, at **12:40 P.M.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Acute Cardiac Dilatation**  
**72A**  
**95B** (duration) **6 hours**

CONTRIBUTOR **Myelogenous Leukemia**  
(SECONDARY) (duration) **1 yrs. — mos. — ds.**

**18. WHERE WAS DISEASE CONTACTED**

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? **No** DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS? **Autopsy**  
(Signed) **A. E. Hale**, M. D.

**4/28/30** (Address) **City Hosp #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**

**Washington Park** DATE OF BURIAL **4/1 1930**

20. UNDERTAKER **Peoples Und. Co.** ADDRESS **3100 Franklin**

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.

1/30