

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

Do not use this space.

14908

791

1003

**1. PLACE OF DEATH**

County.....

Registration District No.....

File No.....

Township.....

Primary Registration District No.....

Registered No.....

City..... *St. Louis* (No.....

**ISOLATION HOSPITAL**

St. .... *24* Ward)

**2. FULL NAME**

*Lloyd Masters*

(a) Residence. No. *920 N. 19th* St., *21* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *6* yrs. *0* mo. *29* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

1. SEX *Male* 2. COLOR OR RACE *White* 3. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-30* 19*30*

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

17. I HEREBY CERTIFY, That I attended deceased from *4-25*, 19*30*, to *4-30*, 19*30*, that I last saw him alive on *4-30*, 19*30*, and that death occurred, on the date stated above, at *10:20 A.M.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 1, 1924*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Pulmonary Tuberculosis (military)*  
*R3A*  
*4/27/30*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
*6 0 29*

(duration) ..... yrs. .... mos. .... ds.

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

CONTRIBUTORY *meningitis Tuberculosis* (SECONDARY)

(duration) ..... yrs. .... mos. *10* ds.

9. BIRTHPLACE (CITY OR TOWN) *St. Louis* (STATE OR COUNTRY) *Mo.*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

10. NAME OF FATHER *Lloyd Masters Sr.*

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

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

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *Alfred P. M. D.* **ISOLATION HOSPITAL**

12. MAIDEN NAME OF MOTHER *Ruth Jackson*

*4-30*, 19*30* (Address)

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

\*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.

14. INFORMANT *Louise Krons* (Address) **ISOLATION HOSPITAL**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

*Phebes Hills* DATE OF BURIAL *May 1 1930*

15. FILED *447-11* 19 *May 1 1930* REG. STAR

20. UNDERTAKER

*Hy Leedner and Co Market St*

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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