

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

Do not use this space.

14948

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. **4385**

St..... Ward)

2. FULL NAME

(a) Residence. No. **3416 LaSalle** St. **18** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **3** 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 **col.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **about 41(?) - -**

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Salem N.C.**

10. NAME OF FATHER **Jordan Spicer**

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

12. MAIDEN NAME OF MOTHER **Mary Hunt**

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

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

15. FILED **47-2-32** 19 **1932** REGISTRAR **Max O'Hanley**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4-30-1930**

17. I HEREBY CERTIFY, That I attended deceased from **4-27-1930** to **4-30-1930** that I last saw him alive on **4-30-1930** and that death occurred, on the date stated above, at **11:40 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
108 (duration) yrs. mos. / **0** ds.

CONTRIBUTORY (SECONDARY) **10/10** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **10/10** 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.

5/2/30 (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 **Chesdale Miss.** DATE OF BURIAL **5/4 1930**

20. UNDERTAKER **Peoples Yrd. 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.

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