

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

Do not use this space.

18091

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *City Hospital #1*

City Hospital #1

File No.

Registered No. **5249**

St. Ward)

2. FULL NAME

THOMAS WILLIAMSON FLOWERS

(a) Residence. No. **3926 College St. 11** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan 1, 1892*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
38 4 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Teamster*
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer *Sullivan Transfer Co.*

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

10. NAME OF FATHER *Frank Riviatkowski*

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

12. MAIDEN NAME OF MOTHER *Don't know*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Don't know*

14. INFORMANT *Dr. Wm. Riviatkowski* (Address) *3926 College*

15. FILED *MAY 29 1934* REGISTRAR *Wm. C. Sherkley*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 26 1930*

17. I HEREBY CERTIFY. That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19..... and that death occurred, on the date stated above, at *8:45 a.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Oedema of Glottis
10.5A

CONTRIBUTORY (SECONDARY) *Cause Unknown* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Wm. Sherkley*, M.D.

5/27 1934 (Address) *Deputy Coroner*

*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

DATE OF BURIAL

Jefferson Barracks *May 29 1930*

20. UNDERTAKER

ADDRESS

Central *1841 Cass*

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.

