

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

Do not use this space.

18152

**1. PLACE OF DEATH**

County ..... Registration District No. 791  
 Township St. Louis Mo. No. 1003 Primary Registration District No. 1003 File No. 5312  
 City St. Louis Mo. City Hospital #2 Registered No. 5312  
 St. .... Ward)

**2. FULL NAME**

(a) Residence No. 1724 Biddle St. 25 Ward. (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 6 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) Separated

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
About 61 — — —

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) God-Carrier  
 (c) Name of employer Unknown

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss

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. Gertrude Creath  
 (Address) City Hosp. #2

15. FILED MAY 31 1930 Max C. Barker REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-26 1930

17. I HEREBY CERTIFY, That I attended deceased from 5/16 1930 to 5/26 1930 that I last saw him alive on 5/26 1930 and that death occurred, on the date stated above, at 6:58 p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Chronic Myocarditis  
93c  
 (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) None  
 (duration) ..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? Home  
 IF NOT AT PLACE OF DEATH, .....  
 DID AN OPERATION PRECEDE DEATH? No DATE OF .....  
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? 2-Ray-Clinical  
 (Signed) A. E. Hale M. D.  
5/27 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 Washington Park Cem DATE OF BURIAL 5-31 1930

20. UNDERTAKER Peoples Und Co Franklin ADDRESS 3100

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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