

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

Do not use this space.

18227

1. PLACE OF DEATH

County..... Registration District No. **791**
 Town..... Primary Registration District No. **1003**
 City **St. Louis** (City or Town) **1904 R Carr.** St. _____ Ward _____

File No. _____
 Registered No. **5423**
 St. _____ Ward _____

2. FULL NAME

(a) Residence No. **1904 R Carr.** St. **D1** 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 **Colored** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Mrs. Mary Bell**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Not known**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
about	48	—	—	—

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

23
7
23
31
29

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**

10. NAME OF FATHER **Not known**

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

12. MAIDEN NAME OF MOTHER **Propia Carr**

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

14. INFORMANT (Address) **Robert Rogers 2913 Bell**

15. FILED **May 3 1930** **Max C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **5-30-1930**

17. **No Physician in attendance**
 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy
92A (non-tubercular)
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) **7401**
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED **7401**

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS (Signed) **John J. Murray**, M. D.

*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.
62-1230 (Address) Deputy Coroner

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Further Unknown** DATE OF BURIAL **6-8-1930**

20. UNDERTAKER **W. S. Wakefield** ADDRESS **4202 Fremont**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

