

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

Do not use this space.

18245

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1002**
City **St. Louis Mo** (No. **Sanitarium**)..... St. Ward)

File No.....
Registered No. **5987**
St. Ward)

2. FULL NAME

(a) Residence. No. **1236 black oak** **13** Ward. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred **66** yrs. + mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>About 66</i>				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Bookbinder*
(b) General nature of industry, business, or establishment in which employed (or employer) *Unknown*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *St. Louis Missouri*

PARENTS

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT *Mr. Summers*
(Address) *5304 Arsenal*

15.

FILED *21 1930* *Max C. Stankoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 28th* 19 *30*

17. I HEREBY CERTIFY, That I attended deceased from *Jan.* 19*28*, to *May 28th* 19*30* that I last saw *him* alive on *May 28th* 19*30* and that death occurred, on the date stated above, at *5:15 A.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
79

CONTRIBUTORY (SECONDARY) *Atherosclerosis*
(duration) *5* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
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) *Mr. Summers*, M. D.
5/28 19 *30* (Address) *5304 Arsenal*

*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 U.* DATE OF BURIAL *6-4 1930*

20. UNDERTAKER *Walter Richter* ADDRESS *3500 Rutger St*

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.

