

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

Do not use this space.

206997
20699
5491

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(No. *City of St. Louis*)

File No.....

Registered No.....

St.....

Ward.....

2. FULL NAME

John ~~Chenier~~ Chenier

(a) Residence No.....

St.....

13

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)

Single

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

✓

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

Don't know

7. AGE

About 62

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

Odd-jobs

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ohio

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

14.

INFORMANT.....

(Address).....

*M. E. Tucker
5800 Arsenal*

15.

FILED.....

19.....

*May 1930
Max C. Barker*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

June 4 1930

17.

I HEREBY CERTIFY, That I attended deceased from.....

June 1, 1930 to June 4, 1930
that I last saw him alive on..... *June 4, 1930*, and that death occurred, on the date stated above, at..... *12:40 A. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*000
Myocarditis Chronic
168
Hemiplegia Apoplectic*

CONTRIBUTORY (SECONDARY)

(duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

POB

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)..... *W. H. ...*, M. D.

6-5-1930 (Address) 5600 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

DATE OF BURIAL.....

Calvary Cemetery June 6 1930

20. UNDERTAKER

ADDRESS.....

J. V. Gebken & Co 2042 McManis

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

7
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