

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

Do not use this space.
20789
~~20789~~ **2087**
 File No. _____
 Registered No. **5586**
 St. _____ Ward _____

1. PLACE OF DEATH

County St. Louis Registration District No. 791
 Township _____ Primary Registration District No. 1003
 City St. Louis (No. City Hospital)

2. FULL NAME

William J. Julian
 (a) Residence No. 4115 Page 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 37 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Emily Julian

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 16 - 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68 3 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) Carpenter
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) England

10. NAME OF FATHER Robert Julian

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

12. MAIDEN NAME OF MOTHER Annie Hill

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

14.

INFORMANT Ray Hospital
 (Address) City Hospital

15.

JUN - 9 1930 FILED 19 Kear & Starling
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 7 1930

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1930 to June 7, 1930 that I last saw him alive on June 7, 1930, and that death occurred, on the date stated above, at 8:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile Dementia
Terminal Pneumonia
Lobar 100
162 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

10/0 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Chemical

(Signed) Carl H. Hote M. D.

6/8 30 (Address) City Hospital

*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

Bellefontaine June 10 1930

20. UNDERTAKER ADDRESS

Astron L & Co 27074 Grand

K. 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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W. H. Ryan.