

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

Do not use this space.

20962

~~21000~~

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. *791*
1003
Primary Registration District No.

File No.
Registered No. *5780*
St. Ward

2. FULL NAME

(a) Residence. No. *2029 Pine* St., *21* 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 *Colord* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Novth unknown 1894*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
abt. 36 *7* *unknown* or

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) *Miss*

10. NAME OF FATHER *John Lewis*

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

12. MAIDEN NAME OF MOTHER *Calixa Wilson*

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

14. INFORMANT *Mary Lewis* (Address) *2029 Pine St*

15. FILED *JUN 14 1930* *Max Barker* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 12 1930*

17. *No Physician*
I HEREBY CERTIFY, That I attended deceased from

..... 19..... to..... 19.....
that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at *6:00 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
96 Captured Aortic Aneurysm

CONTRIBUTORY (SECONDARY) *Non traumatic* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH *91A*

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *J. W. Hughes*, M. D.
6/11/30 (Address) *2620 Lawton*

*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 *Father Dickson* DATE OF BURIAL *June 15 1930*

20. UNDERTAKER *J. W. Hughes* ADDRESS *2620 Lawton*

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.

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

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