

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. 791  
Primary Registration District No. 1003  
(No. South City Hospital #2)

File No. 21378  
Registered No. 6251  
St. .... Ward)

**2. FULL NAME**

Henry Clay  
(a) Residence. No. 21170 Pine St St. 21 Ward.  
(Usual place of abode)  
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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Unk.

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
about 42

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Unknown  
(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) Unknown

10. NAME OF FATHER  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT John J. O'Sullivan  
(Address) 21170 Pine St

15. FILED 19 Mar 2 1930 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 8 1930  
17. Dr. Phyllis Swattenden  
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 2 1/2 11 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Gunshot wound of chest  
173  
(duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) Homicide  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 1917  
IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH? DATE OF.....  
WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) John Phyllis, M. D.  
6/16, 1930 (Address) Deputy Coroner

\*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 Pottersfield DATE OF BURIAL June 28 1930

20. UNDERTAKER Linkie Long ADDRESS 3129

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.

