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.

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

Do not use this space.

[redacted]6
21524

1. PLACE OF DEATH

County ..... Registration District No. 791 1002 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 6485.

City St Louis, Mo. No. City Hospital #2 St. ..... Ward)

2. FULL NAME Jim Dickson

(a) Residence. No. 2914 Market St., 18 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	col.	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-4-1886

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	43	11	23	

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) Unknown
(c) Name of employer "

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

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

14. INFORMANT A. Gertrude Creath
(Address) City Hosp. #2

15. FILED JUL -5 1930, 19 Max C. Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-27-1930

17. I HEREBY CERTIFY, That I attended deceased from 6-26-, 1930, to 6-27-, 1930 that I last saw him alive on 6-27-, 1930 and that death occurred, on the date stated above, at 5 15 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23A (duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (SECONDARY) 31 (duration) ..... 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) A. E. Hale M. D.
6/27, 1930 (Address) City Hospital #2

*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 Park
DATE OF BURIAL 7/7 1930

20. UNDERTAKER Atkins Und Co
ADDRESS 3317 Morgan 80