

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

Do not use this space.

24516

File No. _____
Registered No. 6670
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. 791
Township _____ Primary Registration District No. 1003
City St. Louis Mo (No. City Hospital # 2)

2. FULL NAME

(a) Residence. No. 3641 Lawton Ward. 21
(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 Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Sp
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-6-1903

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
27 1 3

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) Mo

10. NAME OF FATHER Arvan Lloyd

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

12. MAIDEN NAME OF MOTHER Ophelia Stewart

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

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

15. FILED JUL 11 1930
W. C. Starbuck REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-19-1930

17. I HEREBY CERTIFY, That I attended deceased from 6/14, 1930 to 7/19, 1930 that I last saw him alive on 7/19, 1930 and that death occurred, on the date stated above, at 6:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23A

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY)

31

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH unknown

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? NO Post-Mortem
(Signed) Henry S. Hampton, M. D.

(Address) City Hosp # 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 St. Peter's Cem. DATE OF BURIAL July 12, 1930

20. UNDERTAKER J. H. Harrison ADDRESS 2906 Lawton

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

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.

