

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

Do not use this space.

24573

1. PLACE OF DEATH

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

Registration District No. 791
Primary Registration District No. 1003
City Hospital # 2

File No.
Registered No. 6730.
St. Ward)

2. FULL NAME

(a) Residence No. 3058 Thomas 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 15 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-12-1904

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>25</u>	<u>8</u>	<u>25</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ill

10. NAME OF FATHER Joe Camper

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

12. MAIDEN NAME OF MOTHER Della Utstrop

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

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

15. JUL 12 1930 Max C. Garbutt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 7-2 1930 to 7-7 1930 that I last saw him alive on 7-7 1930 and that death occurred, on the date stated above, at 1:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Generalized Peritonitis
1215
129 (duration) yrs. mos. 5 da.
CONTRIBUTORY (SECONDARY) Ruptured Appendix
(duration) yrs. mos. 7 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? yes DATE OF 7-2-30
WAS THERE AN AUTOPSY? (Appendectomy)
WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) H. A. Weathers M. D.

7/9 1930 (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

Washington Park
20. UNDERTAKER
R. M. C. Green

DATE OF BURIAL

7/14 1930
ADDRESS 3517 Pacific

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.

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