

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

Do not use this space.

24732

**1. PLACE OF DEATH**

County.....

Registration District No. 701

Township St Louis  
City St Louis (No. 1610 Cass Ave)

Primary Registration District No. 1005

File No.....  
Registered No. 6891  
St..... Ward)

**2. FULL NAME**

(a) Residence. No. 1614 Cass Ave St. 175 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  
White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)  
Single

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
<u>abt 42</u>	<u>-</u>	<u>-</u>	<u>-</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis  
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Michael Gadell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St Louis  
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER May Calvert

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St Louis  
(STATE OR COUNTRY) Missouri

14. INFORMANT Michael Gadell  
(Address) 5140 Terry Ave

15. JUL 14 1930  
FILED 19  
Wm C Harlow REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

17. No Physician in attendance  
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..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

191 Isolation

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

194

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) John M. W. M. D.

7/14, 19 30 (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

DATE OF BURIAL

Calvary

7-17 1930

20. UNDERTAKER

ADDRESS

Arthur J. Donnelly 2639 West 8

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—THIS IS A PERMANENT RECORD

