

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

Do not use this space.

24983

1. PLACE OF DEATH

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

File No. _____
 Registered No. 7151
 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 1411 Wash St., 25 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. 1 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) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-11-30

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 2 hrs. or 9 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Neal Holman

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

12. MAIDEN NAME OF MOTHER Anna Turner

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

14. INFORMANT A. Luteria Cruz
 (Address) City Hospital #2

15. FILED 11 18 1930 May C. Harkley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-12-1930

17. I HEREBY CERTIFY, That I attended deceased from 7-11-1930, to 7-12-1930, that I last saw him alive on 7-12-1930, and that death occurred, on the date stated above, at 5 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia
Primary
107A (duration) yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY) 1000 (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? Clinical
 (Signed) W. Estabroton, M. D.

7-15-1930 (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 POTTERS FIELD DATE OF BURIAL 7-24-1930

20. UNDERTAKER Erny Aston - 2945 Hawthorn ADDRESS

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.

