

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

791

1002

File No.....

25006

Township.....

Primary Registration District No.....

Registered No.....

7181

City.....

St.....

Ward.....

2. FULL NAME

(a) Residence. No.....

33 36

St.....

21

Ward.....

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos 27 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

1 MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

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

Female Col Single

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

7-4

1930

17.

I HEREBY CERTIFY, That I attended deceased from 6/6 1930 to 7/4 1930 that I last saw him alive on 7/4 1930, and that death occurred, on the date stated above, at 4:30 P. M.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

6-6-30

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, 5 hrs. or 55 min.

28

Premature 159 (duration) yrs. 7 mos. ds.

8. OCCUPATION OF DECEASED

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

mil

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

(c) Name of employer

CONTRIBUTORY (SECONDARY)

1610 (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Mo.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

Unknown

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) 19 19.6 Lathers M. D.

PARENTS

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Scottie Mae (Parent) 7/4 1930 (Address) City Hosp. #2

Unknown

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.

14. INFORMANT

(Address)

Al Gertrude Creath City Hospital #2

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

BATTERS FIELD.

7-24-1930

15. FILED

19 1930

REGISTRAR

20. UNDERTAKER

ADDRESS

Roy Aston

2945 Lathers

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

