

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

Do not use this space.

25105

791

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File No. _____
Registered No. 7305
St. _____ Ward)

1. PLACE OF DEATH

County _____
Township _____
City St. Louis

Registration District No. _____
Primary Registration District No. _____
Mo. Baptist Hosp

2. FULL NAME Charles P. Tervis

(a) Residence. No. 5085 Cabanne Ave. 12 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) March 5 - 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 4 14

8. OCCUPATION OF DECEASED Advertising Business
(a) Trade, profession, or particular kind of work.
(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 Hepp Tervis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Wheeling
(STATE OR COUNTRY) West Virginia

12. MAIDEN NAME OF MOTHER Sarah V. Park

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

14. INFORMANT (Address) Hepp Tervis
5085 Cabanne Ave.

15. JUL 22 1930 FILED _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1930

17. I HEREBY CERTIFY, That I attended deceased from July 15 1930 to July 19 1930 that last saw him alive on July 19 1930, and that death occurred, on the date stated above, at 8:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Toxic goiter
6 to 8
60W (duration) 10 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Idiosyncratic
IF NOT AT PLACE OF DEATH _____

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF July 19, 1930

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Basal Metab. Rate

(Signed) J. T. Dean, M. D.
July 21, 1930 (Address) 410 Metropolitan Bldg

*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 Bellefontaine DATE OF BURIAL July 22 1930

20. UNDERTAKER Hagonson ADDRESS 3121 Olive

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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