

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

Do not use this space.

25269

**1. PLACE OF DEATH**

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis (No. City 100)

File No. ....

Registered No. 7496

**2. FULL NAME**

(a) Residence, No. 221 S Broadway 15 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

**4. COLOR OR RACE**

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

male | white | single

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

Widower

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

Jan 14 1870

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

60 | 6 | 10

**8. OCCUPATION OF DECEASED**

(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

Laborer  
Odd jobs

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

Rhode Island

**10. NAME OF FATHER**

John Riley

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Duland

**12. MAIDEN NAME OF MOTHER**

Catherine Romber

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

St. Louis

**14. INFORMANT**

(Address)

City Hospital  
St. Louis

**15. FILED**

NOV 26 1930

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

July 24 1930

I HEREBY CERTIFY That I attended deceased from June 19 1930 to July 24 1930 that I last saw him alive on July 24 1930 and that death occurred, on the date stated above, at 11 - 24

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Myocarditis  
131  
93C (duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

Chronic Myocarditis  
(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Joseph M. Baker M. D.

\*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

July 26 1930

**20. UNDERTAKER**

ADDRESS

Benesh Hebert 5816

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.

WRITE PLAINLY WITH UNFADING INK—THIS IS PERM. ITEM RECORD

Piley