

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

Do not use this space.

25305

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registered District No.....

1003

City.....

St. Louis

(No.)

Christian Hospital

File No.....

Registered No.

7537

St.

Ward)

2. FULL NAME

Franklin B. Wescoe

(a) Residence. No.

Indianapolis Ind St. 9

Ward.

Indianapolis Ind

(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)

Married

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

Margaret Wescoe

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

March 18 - 1885

7. AGE

YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<i>45</i>	<i>4</i>	<i>9</i>	

8. OCCUPATION OF DECEASED

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

clerk

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

Penn. Ry.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Penn

10. NAME OF FATHER

Franklin B. Wescoe

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Penn

12. MAIDEN NAME OF MOTHER

Francisco Knauss

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Penn

14. INFORMANT

(Address)

*Mrs. Margaret Wescoe
Indianapolis Ind*

15. FILED

28

1930

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

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

July 27 1930

I HEREBY CERTIFY, That I attended deceased from

Jan - 18, 1930, to July 27, 1930
that I last saw h. i. m. alive on *July 27, 1930* and that death occurred, on the date stated above, at *7:45 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Artisan Malaria

83

30

33

(duration) *6* mos. *6* ds.

CONTRIBUTORY (SECONDARY)

General paresis of the insane (duration *12* yrs. mos. ds.)
Luetic

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)

R. M. Williams M. D.

, 19

(Address)

4356 Yarrow

*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

Pittsburgh Penn

July 31 1930

20. UNDERTAKER

ADDRESS

Element Ind Co. S. Grand St

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.

WHITE FLAUNT, WITH UNPAIDING INK—THIS IS A PERMANENT RECORD

