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

Do not use this space.

28253

File No. 8099

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. 701

Township ..... Primary Registration District No. 1009

City St Louis Mo (No. City Hospital #2 St. ..... Ward)

2. FULL NAME Eugene Joyner (Joyner)

(a) Residence. No. 3205 Belle St., 21 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 21 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	Negro	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-7-1880

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
49	8	2	

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) Labor
(c) Name of employer Odd Jobs

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT A. Gertrude Creath
(Address) City Hospital #2

15. FILED AUG 13 1930 Max C Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8 — 9 — 1930

17. I HEREBY CERTIFY, That I attended deceased from 7 — 14 —, 1930, to 8 — 9 —, 1930 that I last saw him alive on 8 — 9 —, 1930, and that death occurred, on the date stated above, at 4:50 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Myocarditis
131
93C (duration) yrs. 4 mos. ds.

CONTRIBUTORY (SECONDARY) Chr. Nephritis
(duration) yrs. 6 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 - Lab.
(Signed) Henry E. Hampton, M. D.
8-11-, 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	DATE OF BURIAL
Rotherdickson	Aug 14 1930
20. UNDERTAKER	**ADDRESS**
Pope J. E.	2931 Lucas ave

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 PLANET, MATH UNFADING INK—THIS IS A PERMANENT RECORD