

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

Do not use this space.

28422

1. PLACE OF DEATH

County.....
Township.....
City St Louis (No.)

Registration District No. 791
Primary Registration District No. 1003

File No.
Registered No. 8302
St. 24th (Ward)

2. FULL NAME

Edward Shaw Jr
(a) Residence. No. 2235 Scott St., 1st Ward.

(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 Colored 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) 6/24/1914

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>16</u>	<u>1</u>	<u>23</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Student
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Edward Shaw
11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Waller
13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Missouri

14. INFORMANT Joe Waller
(Address) ISOLATION HOSPITAL

15. FILED Aug 20 1920
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-17 19 20

17. I HEREBY CERTIFY, That I attended deceased from 8-16, 19 20, that I last saw him alive on 8-16, 19 20, and that death occurred, on the date stated above, at 5:50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

meningitis meningococci
10 (duration) yrs. mos. 3 ds.
CONTRIBUTORY (SECONDARY) 24
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Belknap, M. D.

8-17 19 20 (Address) ISOLATION HOSPITAL

*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

Washington Park 8/20/1920

20. UNDERTAKER Atkins and Co ADDRESS 3317 Morgan 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.

