

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

Do not use this space.

28467

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis, Mo.* (No. *City Hospital #2*)

Registration District No. *791*  
Primary Registration District No. *1003*

File No.....  
Registered No. *8369*  
St. .... Ward)

**2. FULL NAME**

(a) Residence, No. *615 N. E. 1179 St.* *21* Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Male* 4. COLOR OR RACE *Col.* 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) *UNKNOWN*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
*adh 22 - -*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Laborer in*  
(b) General nature of industry, business, or establishment in which employed (or employer) *R.R. Yard*  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Tenn.*

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. Tertude Creach*  
(Address) *City Hospital #2*

15. FILED *AUG 22 1933* *W. C. Marking* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8-20-1930*

17. I HEREBY CERTIFY, That I attended deceased from *8-21-1930*, 1930, to *8-20-1930*, 1930, that I last saw him alive on *8-20-1930*, 1930, and that death occurred, on the date stated above, at *2:45 A. m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Subacute Peritonitis*  
*23A*

*25* (duration) yrs. *2* mos. ds.

CONTRIBUTORY *Pulmonary Tuberculosis* (SECONDARY)

(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? *Chrical - Lob - XRAY*  
(Signed) *Henry G. Hampton*, M. D.

*8-20-1930* (Address) *City Hosp. #2*

\*State the DISEASE CAUSING DEATH, or, in months 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

*Erin, Tenn.* *Aug. 22, 1930*

20. UNDERTAKER ADDRESS

*John E. Pope* *2931 Lucas*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

