

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

Do not use this space.

28677

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... (No. **2817**) **Walnut** St. (Ward)

File No.
Registered No. **8587**

2. FULL NAME

(a) Residence No. **2817 Walnut** St., **22** 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 **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) **April 20 - 1889**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
41 4 8

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Teacher**
(b) General nature of industry, business, or establishment in which employed (or employer) **City**
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) **St Louis** (STATE OR COUNTRY) **Mo**

10. NAME OF FATHER **Alford Sharts**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) **Mo**

12. MAIDEN NAME OF MOTHER **Marion Peters**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) **Miss**

14. INFORMANT **Walter J. Simpson** (Address) **4260 Ennighway**

15. FILED **ALG 30 1930** REGISTRAR **W. C. ...**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug 28 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Aug 19** 19**30**, to **Aug 28** 19**30**, that I last saw him alive on **Aug 20** 19**30**, and that death occurred, on the date stated above, at **7:30 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Rupture of Aneurysm of Aorta
9/10

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) **Aneurysm of Aorta** (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED **at home**

19. DID AN OPERATION PRECEDE DEATH? **no.** DATE OF _____

WAS THERE AN AUTOPSY? **no.**

WHAT TEST CONFIRMED DIAGNOSIS? **clinique**
(Signed) **Lucretia M. D.**
VIII-28-1930 (Address) **225 Franklin**

*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 **father's Dickson** DATE OF BURIAL **9/1 1930**

20. UNDERTAKER **Richardson + Tyler** ADDRESS **1020 Brooklyn 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.

