

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

Do not use this space.

29940

1. PLACE OF DEATH

County Eastern
Township Franklin
City St. Louis

Registration District No. 399
Primary Registration District No. 1007

File No. _____
Registered No. 2745
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2014 1/2 E. 18 St. 11 Ward _____

(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 negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 4-1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
33 4 19

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) Portage Mo

10. NAME OF FATHER Benjamin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) North

12. MAIDEN NAME OF MOTHER Ellie Evers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill

14. INFORMANT Bessie Brown
(Address) 1014 S. Jackson St. St. Louis

15. FILED 9/12 1930 M. M. Carver REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-11-30

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart Regurgitation

92A (duration) yrs. mos. ds.
990

CONTRIBUTORY (SECONDARY) gastritis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Ill
IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Dr. [Signature]
(Address) Deputy Coroner

*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 Portage Mo DATE OF BURIAL 11-17-30

20. UNDERTAKER W. W. Fisher ADDRESS 1217 [Address]

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.

