

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

Do not use this space.
29946

1. PLACE OF DEATH

County Jefferson Registration District No. 399 File No. _____
Township Richmond Primary Registration District No. _____ Registered No. 3751
City St. Louis (No. 1) General Hospital #2 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 196 Henry Jones 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

2. SEX Male 4. COLOR OR RACE Caucasoid 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) unknown

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>57</u>				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Coal Vendor
(b) General nature of industry, business, or establishment in which employed (or employer) Leads Mfgs Coal Co
(c) Name of employer _____

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

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 (Address) R. G. Mo

15. FILED 9/2 1930 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/13 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1930 to Sept 19 1930 that I last saw h. alive on Aug 31 1930 and that death occurred, on the date stated above, at General Hospital #2

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ob. Respir
Myocardial infarction
2A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 900 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH no

0 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS Biopsy
(Signed) Dr. M. M. Brown, M. D.

9/2, 1930 (Address) Genl 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 Leads Farm DATE OF BURIAL Sept 12 1930

20. UNDERTAKER Went Appleton & Jones ADDRESS 1600 E 19

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.

