

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

Do not use this space.

**31285**

**1. PLACE OF DEATH**

County .....

Registration District No. **1003**

File No. ....

Township .....

Primary Registration District No. ....

Registered No. **8883**

City **St. Louis** (No. **Petresda Hospital** St. Ward)

**2. FULL NAME**

(a) Residence. No. **4472 Finney Ave., 11** St. 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**

**4. COLOR OR RACE**

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

**6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

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

**7. AGE**

YEARS

MONTHS

DAY

If LESS than 1 day, ..... hrs. or ..... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

(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)

**10. NAME OF FATHER**

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

**14. INFORMANT**

(Address)

**15. FILED**

SEP 11 1930

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Sept. 9<sup>th</sup> 1930

**17. I HEREBY CERTIFY, That I attended deceased from** Sept 5, 1930, to Sept 9, 1930, that I last saw him alive on Sept 9, 1930, and that death occurred, on the date stated above, at 9:00 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Broncho Pneumonia (Primary)**

**CONTRIBUTORY (SECONDARY)** 1077A (duration) yrs. mos. ds. 16

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

**18 DID AN OPERATION PRECEDE DEATH? DATE OF.....**

WAS THERE AN AUTOPSY? **no**

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) **Emory T. Leppin, M. D.**

\*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**

**Lake Charles, Elm. Spr., 12, 1930.**

**20. UNDERTAKER**

ADDRESS **1820**

**Jas. W. Clock** **Hodinson Ave.**

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.

WRITE IN PLAIN, WITH CHANGING INK—THIS IS A PERMANENT RECORD

