

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **1308 A North 8 St**)

31713

File No.
Registered No. **9369**
St. Ward)

2. FULL NAME

(a) Residence. No. **1308 A North 8** St., **25** 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 Colored	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Susie West				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known				
7. AGE Always 60	YEARS —	MONTHS —	DAYS —	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Blacksmith (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)
La. Ga.

PARENTS	10. NAME OF FATHER Marshall West
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) La.
	12. MAIDEN NAME OF MOTHER Not known
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) " "

14. INFORMANT **Susie West**
(Address) **1308 A North 8 St**

15. FILED **SEP 29 1930**
W. C. Staveland
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 26 - 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Sept 19** 19**30**, to **Sept 26** 19**30** that I last saw him alive on **Sept 24** 19**30** and that death occurred, on the date stated above, at **6:24 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1. Acute myo carditis
chronic mitralis
reflex
(duration) **1** yrs. **1** mos. **—** ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? **no** DATE OF
WAS THERE AN AUTOPSY? **no**
WHAT TEST CONFERRED? **microscope**
(Signed) **W. C. Staveland**, M. D.
9/26/30 (Address) **336 Frank**

*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: **Truett Dickson** DATE OF BURIAL **9-30-1930**

20. URBERTAKER **W. C. Staveland** ADDRESS **4202 Timney**

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.

