

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

Do not use this space.

34375

1. PLACE OF DEATH

County St. Louis
Township W. 11
City St. Louis

Registration District No. 791
Primary Registration District No. 4013

File No. _____
Registered No. 9732
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 914 Morgan St. 25 Ward.

(If nonresident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-2-1907

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>23</u>	<u>8</u>	<u>7</u>	

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) Chauffeur
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Illinois

10. NAME OF FATHER Mrs. McDonald

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

12. MAIDEN NAME OF MOTHER Mattie Gouty

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

14. INFORMANT A. Stetson Orsath (Address) City Hospital 2

15. FILED Oct 13 1930 made stars copy REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-9-30

17. I HEREBY CERTIFY That I attended deceased from 10-27-30, 1930, to 10-29-30, 1930, that I last saw him/her alive on 10-29-30 and that death occurred, on the date stated above, at 12 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia Thoracis
1104 (duration) yrs. mos. 4 da.
CONTRIBUTORY (SECONDARY) lobar pneumonia
1010 (duration) yrs. mos. 14 da.

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

DID AN OPERATION PRECEDE DEATH? yes DATE OF 10-8-30
WAS THERE AN AUTOPSY? (Thoracotomy)

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. H. Leathers, M. D.
11/10, 1930 (Address) City Hospital 2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greenwood DATE OF BURIAL Oct 13 1930

20. UNDERTAKER A. L. Beal Under ADDRESS 2726 Lucas

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

