

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City St. Louis Mo. (No. ....)

Registration District No. 791  
Primary Registration District No. 1003  
Sanitarium

File No. 34528  
Registered No. 9904  
St. .... Ward)

**2. FULL NAME**

(a) Residence, No. 7816 Ivory Apt. 13 Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. + mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 19 - 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
71 9 28

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Car Repairer  
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown  
(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Mississippi

**10. NAME OF FATHER**

Unknown

**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 W.F. Williams  
(Address) 5400 Arsenal

**15.**

FILED 19 Mar 6 Starkloff  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 17th 1930

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1928, to Oct 17th 1930  
that I last saw h. (N.) alive on Oct 17th, 1930, and that death occurred, on the date stated above, at 2:52 a.m.

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

Chronic Myocarditis  
(duration) 5 yrs. 8 mos. 12 ds.  
CONTRIBUTORY Arteriosclerosis +  
(SECONDARY) Hypertension (duration) 5 yrs. 8 mos. 12 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 CONFIRMED DIAGNOSIS? Clinical Findings

(Signed) William F. Williams M. D.

10-17 1930 (Address) 5400 Arsenal

\*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**

New St. Marcus Ch Oct 20 1930

**20. UNDERTAKER**

**ADDRESS**

C. J. Schurr 3128 Lafayette Ave

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.

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14