

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

Do not use this space.

34543

791

1003

File No. _____
Registered No. **9919**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City **St. Louis** (No. **City Hospital #2**)

2. FULL NAME

Wilson Jeffries, Jr.
(a) Residence. No. **2909 Laclede** St. **21** Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **19** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male** 4. COLOR OR RACE **col** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **single**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **10-16-1930**

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

17. I HEREBY CERTIFY, That I attended deceased from **9-22-1930**, to **10-16-1930**. that I last saw him alive on **10-16-1930**, and that death occurred, on the date stated above, at **4:45 A** m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **7-4-1900**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|--------|-----------|----------|-----------|----------------------------------|
| | 30 | 3 | 12 | |

Pulmonary Tuberculosis

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Chauffeur**
(b) General nature of industry, business, or establishment in which employed (or employer) **Taxi-Cab Business**
(c) Name of employer _____

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) **Unknown**
(duration) _____ yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) **Ky**
(STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED **Unknown**
IF NOT AT PLACE OF DEATH _____

10. NAME OF FATHER **Wilson Jeffries**

DID AN OPERATION PRECEDE DEATH? **NO** DATE OF _____

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

19. WAS THERE AN AUTOPSY? **Yes**
WHAT TEST CONFIRMED DIAGNOSIS **Autopsy - Lab-KRAY**
(Signed) **Henry C. Hampton** M. D.
(Address) **City Hospital #2**

12. MAIDEN NAME OF MOTHER **Phoebe Taylor**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Ky**
(STATE OR COUNTRY)

14. INFORMANT **A. Gertrude Creath**
(Address) **City Hospital #2**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Greenwood Cem** DATE OF BURIAL **10-18-1930**

15. FILED **19** 19 **19** **Marb Starkeoff** REGISTER

20. UNDERTAKER **People's Burial Co** ADDRESS **Franklin**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

