

**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**  
**1003**  
Primary Registration District No. *Sanitarium*

File No. **34970**  
Registered No. **10373**  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. *1106 So. 18th* St., *13* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *30 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 *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug. 3, 1877.*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
*53 2 29*

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Railroad switchman*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Railroad*  
(c) Name of employer *Terminal S. P. Association*

9. BIRTHPLACE (CITY OR TOWN) *Union City*  
(STATE OR COUNTRY) *Tennessee*

10. NAME OF FATHER *Unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) "  
(STATE OR COUNTRY) *Tennessee*

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) "  
(STATE OR COUNTRY) *Tennessee*

14. INFORMANT *B. T. Koon, M. D.*  
(Address) *5300 Arsenal St.*

15. FILED *NOV - 1 1930* *Max C. Starker* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *October 31 1930*

17. I HEREBY CERTIFY, That I attended deceased from *October 6*, 1930, to *October 31*, 1930, that I last saw him alive on *October 31*, 1930, and that death occurred, on the date stated above, at *7:15 P. m.*

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

*General paralysis of the Insane (Syphilis)*

CONTRIBUTORY (SECONDARY) **76** (duration) ..... yrs. .... mos. .... ds.

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

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

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Reed's Spinal Wasserman*  
(Signed) *Reed T. Koon*, M. D.

*10/31, 1930* (Address) *5300 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 *Sunset Cemetery* DATE OF BURIAL *11-3 1930*

20. UNDERTAKER *McLaughlin* ADDRESS *1631 main*

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.

