2-Ar
9-7-1929

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 1003 File No. 37381

Township ..... Primary Registration District No. ..... Registered No. 10419

City ..... (No. 7010 S. Broadway St. ..... Ward)

2. FULL NAME Evisto Diaz

(a) Residence. No. 7010 S. Broadway St., 1 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 7-1929

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	1	3	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Julius Diaz
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Spain
12. MAIDEN NAME OF MOTHER Eliona Menendez
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Spain

14. INFORMANT Julius Diaz
(Address) 7010 S Broadway

15. FILED NOV -3 1930 Max C. Hardy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-1- 1930

17. I HEREBY CERTIFY, That I attended deceased from 10/28, 1930, to 11/1, 1930 that I last saw him alive on 11/1, 1930, and that death occurred, on the date stated above, at 00 m.

107A THE CAUSE OF DEATH* WAS AS FOLLOWS: 2 A.
101A
Broncho-Pneumonia
Primary
(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (SECONDARY) Bronchitis acute non Tubercular (duration) ..... yrs. ..... mos. 5 or 6 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 1000
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) C. R. Hawker, M. D.
11/1-, 1930 (Address) 7219 Michigan

*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
Mount Hope	11-3 1930
20. UNDERTAKER	ADDRESS 6320
Southern	S. Grand Blvd

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.