

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

Do not use this space.

38062

1. PLACE OF DEATH

County..... Registration District No. 791
 Townshp..... Primary Registration District No. 1073
 City St. Louis (No. 5370 Pershing Ave. St. _____ Ward _____)

2. FULL NAME

William B. Homer
 (a) Residence. No. 5370 Pershing Ave. St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 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 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 H. Louie Homer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 29, 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
81 3 27

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Lawyer
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Brimfield
 (STATE OR COUNTRY) Mass.

PARENTS
 10. NAME OF FATHER Alured Homer
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Brimfield
 (STATE OR COUNTRY) Mass.
 12. MAIDEN NAME OF MOTHER Ruth Bliss
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Brimfield
 (STATE OR COUNTRY) Mass.

14. INFORMANT Coland M. Homer
 (Address) 7541 Novella Park

15. FILED _____, 19 30 Max C. Harley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 16 19 30

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1 1930, to Nov 20 1930, and that I last saw him alive on Nov 20 1930, at 5 P. m. and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy cerebral
Hemorrhage
 (duration) yrs. mos. ds. 1

CONTRIBUTORY (SECONDARY) Arterio-sclerosis
 (duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? Not applicable
 IF NOT A PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) W. Kieffer M. D.

Nov 16, 1930 (Address) 1500 Olive

*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 Bellefontaine DATE OF BURIAL Nov 29 1930

20. UNDERTAKER Wagoner ADDRESS 3621 Olive

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.

