

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

Do not use this space.

38065

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis (No. 6764 W. Park av. .... St. .... Ward)

File No. ....  
 Registered No. 11219

**2. FULL NAME**

Seth Lester,

(a) Residence No. .... St. 4 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Minnie Lester

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1873-12-24

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .... hrs. or .... min.
	<u>56</u>	<u>11</u>	<u>2</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Carpenter  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer Shell Petroleum

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

(STATE OR COUNTRY) Indiana

PARENTS

10. NAME OF FATHER James Lester,

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....  
 (STATE OR COUNTRY) Indiana

12. MAIDEN NAME OF MOTHER Josephine Carrell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....  
 (STATE OR COUNTRY) Indiana

14. INFORMANT Minnie Lester  
 (Address) 6764 W. Park av.,

15. FILED 19 30 May 20 1930  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/26 -- 19 30

17. I HEREBY CERTIFY, That I attended deceased from .....  
 to 11-26-, 19 30  
 that I last saw him alive on 11-26-, 19 30 and that death occurred, on the date stated above, at 1:05 P. m.

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

Ruptured appendix  
Intestinal Obstruction  
General Peritonitis  
191 B (duration) .... yrs. .... mos. 3 da.  
 CONTRIBUTORY (SECONDARY) Emphysema of the lung  
Adv. Pulm. T. M. Inductive (duration) .... yrs. .... mos. .... da.

18. WHERE WAS DISEASE CONTRACTED? Not known

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Nov 24th

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy report  
 (Signed) N. O. Specter, M. D.

11/27/1930 (Address) University Club Bldg.

\*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

Mt. Lebanon,

DATE OF BURIAL

11/29/30,

20. UNDERTAKER

Robt. J. Ambrose  
479 N. Euclid

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.

