

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

Do not use this space.

40941

1. PLACE OF DEATH

County.....

Registration District No. 791

File No.

Township.....

Primary Registration District No. 1002

Registered No. 11598

City St. Louis (No. City Hospital #1)

City Hospital #1

St. Ward

2. FULL NAME

Benjamin B Sawyer

(a) Residence. No. 4414 Delmar Ave. 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 Anna L Sawyer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 2-1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
69 8 7

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

9. BIRTHPLACE (CITY OR TOWN) Illinois
(STATE OR COUNTRY)

10. NAME OF FATHER Frank Sawyer

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

12. MAIDEN NAME OF MOTHER Sarah Grant

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

14. INFORMANT Mrs Anna L Sawyer
(Address) 4414 Delmar Ave

15. FILED DEC 11 1930 M. E. J. [Signature] REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 9 1930

17. To Physician in attendance
I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
that I last saw h..... alive on 19..... and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
164c
Fuel Gas Poisoning
(self administered)
suiciding (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Suicide (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 160
IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) J. W. Kerney M.D.
12/10, 1930 (address) Deputy Coroner

*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 West Frankfort Ills DATE OF BURIAL 12/11 1930

20. UNDERTAKER Arthur Donnelly 2039 Wash St ADDRESS

K. 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.

WHAT ARE YOU DOING INK—THIS IS A PENCIL RECORD

