

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

Do not use this space.

1262

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Ham Primary Registration District No. _____
 City St. Louis, Mo. 820 E. 8th St.

File No. _____
 Registered No. 121
 St. _____ Ward _____

2. FULL NAME

(a) Residence No. 820 E. 8th St. St. 1 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 Male
 4. COLOR OR RACE Colored
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
 5a. If MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Single
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1890
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 40

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Common Labor
 (b) General nature of industry, business, or establishment in which employed (or employer) 2:17
 (c) Name of employer _____

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Edna Grimes
 (Address) 709 Locust St.

15. Jan 8 31 M. M. Coraue REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-2-1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Homicide - Firearm

CONTRIBUTORY (SECONDARY) 173 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH, _____ DATE OF _____
 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) Dr. [Signature]
 _____, 19____ (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 Highland Cemetery DATE OF BURIAL 1-8-1931

20. URBERTAKER West, Ophelia Jones ADDRESS 1600 E. 19

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.

WHILE FILING WITH UNDERLYING INSTRUMENTS THIS IS A PERMANENT RECORD

