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.

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

2832

1. PLACE OF DEATH
County St. Louis — Registration District No. 1120 — File No.
96 Township Carondelet — Primary Registration District No. 6 228 B. — Registered No. 4
City Koch, Mo. (No. Koch Hosp St. Ward)

2. FULL NAME Roosevelt Shampklin
(a) Residence. No. 4355 Cottage Ave. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 4, 1904

7. AGE — YEARS: 26 — MONTHS: 7 — DAYS: [illegible] — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): 2.36
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri 1

PARENTS
10. NAME OF FATHER: Solomon Shampklin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Kentucky 2
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown 31

14. INFORMANT: Robert Koch Hospital
(Address) Koch, Mo.

15. FILED 1-6, 1930 L. C. Obrock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 3, 1931 19

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1930 to Jan. 3, 1931, 19 that I last saw him alive on Jan. 3, 1931 and that death occurred, on the date stated above, at 1-30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

2312 (duration) yrs. 9 mos. 16 ds.

CONTRIBUTORY (SECONDARY) 2312 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED St. Louis, Mo.
IF NOT AT PLACE OF DEATH
0 DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. Stolar (1), M. D.
1/4, 1931 (Address) Koch, Mo.

*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: Father Dickson — DATE OF BURIAL: 1-7-1931

20. UNDERTAKER: [illegible] — ADDRESS 4202 [illegible]

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

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

City..... (No....., ...St. .....Ward)

2. FULL NAME.....

(a) Residence. No..... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

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

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

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

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTY)

14.
INFORMANT.....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.
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:

.....
.....
.....
..... (duration) .....yrs.....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)
..... (duration) .....yrs.....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)..... ....., M. D.

, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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