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.

FEB 2

CERTIFICATE OF DEATH

File No. 2847

Registered No. 36

1. PLACE OF DEATH

County St. Louis

Township Carondelet

City Koch

Registration District No. 112

Primary Registration District No. B,

(No. Koch Hosp. St. Ward)

2. FULL NAME TRUITT, GARLAND

(a) Residence. No. 1207 N 17th St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
MALE	COLORED	DIVORCED

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) JAN 27, 1885

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	45	11	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Garland Truitt

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

12. MAIDEN NAME OF MOTHER Annie Pitcher

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

14. INFORMANT Koch Hospital Records
(Address) " Mo

15. FILED 1-24-31 L. C. Obert REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 22 1931 19

17. I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1928, to Jan. 22, 19, that I last saw h. alive on Jan. 22 1931, 19, and that death occurred, on the date stated above, at 3:15 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

About (duration) 4 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Gastro-Intestinal Tbc

About (duration) 1 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Unknown

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Findings

(Signed) J. Stolz, M. D.

1/22/31 (Address) Koch Hospital

*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
New Franklin Mo	1-28 1930
20. UNDERTAKER	**ADDRESS**
Duncan Und. Co	New Franklin Mo.

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 COUNTRY)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

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

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