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

Do not use this space.

3055

File No. 240
Registered No.

1. PLACE OF DEATH

County ..... Registration District No. 701
Township ..... Primary Registration District No. 1003
City ..... (No. ..... SOLATION HOSPITAL ..... St. ..... Ward)

2. FULL NAME Raymond Christopher

(a) Residence. No. 2633 Ohio St., 23 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)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 11, 1929

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	1	9	25	

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) St. Louis
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Ross Christopher
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Sally Swafford
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo

14. INFORMANT Joe Taffler
(Address) SOLATION HOSPITAL

15. FILED ..... -7 1931, 19 ..... Mary C. Starcher
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-5 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1930, to Jan 5, 1931 that I last saw h. ~~live~~ alive on Jan 5, 1931, and that death occurred, on the date stated above, at 10 45 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1 Measles
10 A (duration) yrs. mos. 12 ds.
CONTRIBUTORY (SECONDARY) Bronchopneumonia
Secondary (duration) yrs. mos. 7 ds.

18. WHERE WAS DISEASE CONTRACTED
NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Findings
(Signed) L. F. Tompare M. D.
, 19 (Address) SOLATION 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 Doerun St Francis Co. Mo
DATE OF BURIAL Jan 7 1931
20. UNDERTAKER J. H. Gebken
ADDRESS 2630 Gravois

Be careful and accurately 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.