

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.

MAR 27 1931

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

6999

1. PLACE OF DEATH St. Louis
 County Central Registration District No. 1160
 Township University Primary Registration District No. 4470
 City St. Louis No. _____ St. _____ Ward _____

2. FULL NAME Isaac Newton Bruce
 (a) Residence No. 600 Washington Ave St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 10 yrs. 4 mos. 4 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. 26
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 20th. 1847

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>83</u>	<u>9</u>	<u>23</u>		

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work 1
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Wakenyan
 (STATE OR COUNTRY) Ohio

10. NAME OF FATHER Chas. W. Bruce

11. BIRTHPLACE OF FATHER (CITY OR TOWN) X 51
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Sabry M. Doud

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

14. INFORMANT Mary E. Craig
 (Address) 600 Washington Ave.

15. FILED 2-24-19-31 Lena V. Mueller
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/23 1931

17. I HEREBY CERTIFY, That I attended deceased from 2-1-30 19____, to 2-23-1931, and that I last saw him alive on 2-22, 1931, and that death occurred, on the date stated above, at 6:20 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
10R
192R
 (duration) yrs. mos. 2 ds.

CONTRIBUTORY United Suffering
 (SECONDARY) (duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? No DATE OF.....
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. H. Myers M. D.
2-23-1931 (Address) 6022 Grand St.

*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 <u>Valhalla Cemetery</u>	DATE OF BURIAL <u>2/25 1931</u>
20. UNDERTAKER <u>Shepard Funeral Home</u>	ADDRESS <u>1167-69 Hamilton Ave.</u>

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 1160
Township University City Primary Registration District No. 4470
City University City St. _____ Ward _____

File No. _____
Registered No. 26

2. FULL NAME

Isaac Newton Bunch
(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. UNDERTAKER (ADDRESS)

20. FILED April 8, 1931 Lena V. Moeller Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/23, 1931

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Pneumonia - lobar Date of onset _____

Other contributory causes of importance:

mitral insufficiency

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external cause (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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