

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

Do not use this space

7516

791
1003

1. PLACE OF DEATH

County Registration District No.
Township Primary Registration District No.
City St. Louis (No. City) City Hospital St. Ward)

File No.
Registered No. 1862

2. FULL NAME

(a) Residence. No. City Hospital St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) march 12, 1875

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>55</u>	<u>10</u>	<u>29</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Houseman
(b) General nature of industry, business, or establishment in which employed (or employer) 1125 K 1A 1031
(c) Name of employer

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT E. Rowan
(Address) City Hospital

15. FILED 72 REGISTRAR E. Starkey

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 10 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1931, to Feb. 10, 1931, that I last saw him alive on Feb. 10, 1931, and that death occurred, on the date stated above, at 10:35 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute laryngitis, Streptococic
toxic edema of Glottis
epithelioma
(duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 2/11/31

WAS THERE AN AUTOPSY? Only trachea & only, ante mortem

WHAT TEST CONFIRMED DIAGNOSIS? Tracheostomy

(Signed) Ernest Simon, M. D.

2/10, 1931 (Address) City 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 New St Marcus DATE OF BURIAL Feb 13 1931

20. UNDERTAKER McLaughlin ADDRESS 1631 mo ave

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.

Woodson