

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

Do not use this space.

7647

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

St. Louis

(No. **4729**)

Hammett Place

File No.....

Registered No. **2008**

St.

Ward)

2. FULL NAME

(a) Residence No.

6

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

Male

4. COLOR OR RACE

white

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)

Dec 11 - 1896

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

34

2

3

8. OCCUPATION OF DECEASED

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

Chauffeur

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

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(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Missouri

10. NAME OF FATHER

John Troy

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Missouri

12. MAIDEN NAME OF MOTHER

Ella Keating

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Missouri

14.

INFORMANT

(Address)

Mr. Lillian Troy 4729 Hammett Place

15.

FILED

15

1931

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Feb. 14 1931

17.

I HEREBY CERTIFY, That I attended deceased from

Feb. 5th 1931 to Feb. 13 1931

that I last saw him alive on *Oct. 13 1931*, and that death occurred, on the date stated above, at *2:50 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

(duration) *2 yrs 2 mos* ds.

CONTRIBUTORY (SECONDARY)

Peri-rectal abscess Tubercular (duration) *1* 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)

2/14/1931 (Address) 2435 N. Grand Ave

*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

Calvary Cemetery

2/17 1931

20. UNDERTAKER

ADDRESS

Arthur J. Donnelly 2039 Wash St

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.

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