

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

Do not use this space.

12647

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo** (No. **City Hosp #2**)

File No.....

Registered No. **3957**

St. .... Ward)

**2. FULL NAME**

(a) Residence, No. **City Jail** St., **25** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **6** 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

**Col**

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)

**6-4-1907**

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, .... hrs. or .... min.

**23**

**9**

**20**

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)

**Miss**

(STATE OR COUNTRY)

10. NAME OF FATHER

**Walter Barnes**

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

**Miss**

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

**Mamie Submitt**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

**Miss**

(STATE OR COUNTRY)

14. INFORMANT

(Address)

**a. Gertrude Lynch  
City Hosp #2**

15. FILED

19

**Walter H. Farley**  
REGISTRAR

**1 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **3-24** 19**31**

17. I HEREBY CERTIFY, That I attended deceased from **3/22**, 19**31**, to **3/24**, 19**31**, that I last saw h. **alive** on **3/24**, 19**31**, and that death occurred, on the date stated above, at **2:10 p.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**224**  
**Pulmonary T.B**  
**Tuberculosis** (duration) **2** yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

**Unknown**

19. DID AN OPERATION PRECEDE DEATH? **No** DATE OF

20. WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **Henry E. Hough**, M. D.

\*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

**Washington U** **3/27** 19**31**

20. UNDERTAKER

ADDRESS

**W. Richter** **3500 Katze**

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.

