

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

Do not use this space.

15674

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1000**

City **St. Louis** (No. **City Hosp**)

File No.....

Registered No. **4111**

St. Ward)

2. FULL NAME

(a) Residence. No. **2007 No. Parkway 26** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **5** yrs. mos. **0** 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) **Not known**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hra. ormin.
About 55				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Painter**
(b) General nature of industry, business, or establishment in which employed (or employer) **69**
(c) Name of employer

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

10. NAME OF FATHER **James Adams**

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

12. MAIDEN NAME OF MOTHER **Helen Sharp** 4/3, 1931 (Address) **City Hosp**

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

14. Hospital information (Address) **City Hospital**

15. **ADR - 4 (93)** FILED: **1931** **W. J. Parker** REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 3rd 1931**

17. I HEREBY CERTIFY, That I attended deceased from **Feb. 9th, 1931** to **April 3rd, 1931** that I last saw him alive on **April 3rd, 1931**, and that death occurred, on the date stated above, at **6:45 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral sclerosis
Chronic myocarditis
87 5/8
930 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **574 Hypertrophic arthritis** (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? **refused** No

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical & autopsy**
(Signed) **W. Scherman** 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 **New Peckers** DATE OF BURIAL **April 4, 1931**

20. UNDERTAKER **W. J. Leidner Ind Co** ADDRESS **1417 N. Market**

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.

