

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

Do not use this space.

15708

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... **St. Louis Mo.** (No. **2323 Geyer**)

File No.....
Registered No. **4153**
St. Ward)

2. FULL NAME Samuel Northup

(a) Residence. No. **2323 Geyer** St. **23** Ward. (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) Married		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Northup				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9/22/1863				
7. AGE YEARS 67	MONTHS 6	DAYS 11	IF LESS than 1 day, hrs. or min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... Merchant (b) General nature of industry, business, or establishment in which employed (or employer)..... Antique (c) Name of employer..... Self				

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)..... **N.Y.**

PARENTS	10. NAME OF FATHER Thomas Northup
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)..... N.Y.
	12. MAIDEN NAME OF MOTHER Elyra Smith
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)..... N.Y.

14. INFORMANT..... Sarah Northup
(Address) **2323 Geyer**

15. FILED - 5 1931
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4/3/31** 19
17. I HEREBY CERTIFY, That I attended deceased from **3-28-31**, 19..... to **4-3-31**, 19..... that I last saw him alive on **4-3-31**, 19..... and that death occurred, on the date stated above, at **6.20 P.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Myocarditis
13!
93A (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **Myrdia (Chronic)** (duration) 5 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 AUTOPT? **No**
WHAT TEST CONFIRMED DIAGNOSIS?
4/4/31 (Signed) **Robert W. Main**, M. D.
(Address) **3532 Washington**

*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 **Wallingford N.Y.** DATE OF BURIAL **4-5-1931**
20. UNDERTAKER **M^s Laughlin** ADDRESS **1631 2nd 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.

3532 Wash

12-2