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

Do not use this space.

15922

File No. 4394

Registered No.

1. PLACE OF DEATH

County

Township

City St. Louis (No. City Hospital St. Ward)

Registration District No. 1003 791

Primary Registration District No.

2. FULL NAME James W. White 20761

(a) Residence. No. 4707 Easton St., 6 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 13 - 1901

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	29	10	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) 226
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER J. L. White
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Tenn.
12. MAIDEN NAME OF MOTHER Louise Faust
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Tenn.

14. INFORMANT Hosp. Information Dept. Hosp.
(Address) City Hosp.

15. FILED 1931 Mary C. Tarlton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 7th 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27th, 1931, to April 7th, 1931 that I last saw him alive on April 7th, 1931, and that death occurred, on the date stated above, at 1:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Bronchitis
1108 not tuberculous
1028 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Pleural effusion
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH No
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? Refused No
WHAT TEST CONFIRMED DIAGNOSIS Clinical, X-ray

(Signed) Jerome Simon, M. D.
4/7 1931 (Address) City Hosp.

*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 St. Matthews — DATE OF BURIAL 4/10 1931

20. UNDERTAKER Gazaulen Bros — ADDRESS 2621 Cherrell

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD