

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

Do not use this space.

16616

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

File No.....

Registered No.....

5139

St..... Ward)

2. FULL NAME

(a) Residence, No..... Ward.....

(Usual place of abode) 2044 N. 114th

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 7 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)

widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

May 28 - 1863

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

67

10

27

8. OCCUPATION OF DECEASED

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

Laborer

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

277

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Mr. Thompson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. Hospital Information

INFORMANT.....

(Address).....

15. FILED

APR 30 1931

19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

April 24th 1931

17.

I HEREBY CERTIFY, That I attended deceased from April 23rd 1931 to April 24th 1931 that I last saw him alive on April 24th 1931, and that death occurred, on the date stated above, at 6:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Cardiovascular renal disease

131 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(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? NO

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) W. Scherman, M. D.

425, 1931 (Address) City Hospital

*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

St. Louis

4/29/31

20. UNDERTAKER

ADDRESS

W. Richter 300 Rutger

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.

Thompson -