

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

Do not use this space.

23312

1. PLACE OF DEATH

County.....

Registration District No. **701**

Township.....

Primary Registration District No. **1003**

City *St. Louis*

(No. *1918*) *Plan*

File No.....

Registered No. **6776**

St.....

Ward)

2. FULL NAME

(a) Residence. No. *1918* *Plan* St., *21* Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Mary Leopold

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

Unknown

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

About 40

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

Laborer

337

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT

(Address) *1918 Plan*

15. FILED

22 19*31*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6-15-1931*

17. I HEREBY CERTIFY, That I attended deceased from *6-13-31*
....., 1931, to *6-15-* 1931,
that I last saw ~~him~~ *her* alive on *6-15-* 1931, and that death occurred, on the date stated above, at *437* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Gastritis 1180

from eating (duration) yrs. mos. *2* ds.

CONTRIBUTORY (SECONDARY)

Dotted Hours (duration) yrs. mos. *4* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical Symptoms*

(Signed) *S. B. Walthall*

..... M. D.

, 19 (Address) *1001-1/2 - Jefferson*

*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

Jefferson/Barick *6-22-1931*

20. UNDERTAKER

ADDRESS

W. S. Wade and Co., Jimmy

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.

