

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

Do not use this space.

29690

1. PLACE OF DEATH

County..... Registration District No. 782
 Township..... Primary Registration District No. 101
 City St. Louis (No. ISOLATION HOSPITAL) St. _____ Ward _____

File No. _____
 Registered No. 8722

2. FULL NAME

Maurice Smith
 (a) Residence, No. 5655 2nd Avenue, St. Louis 20, Mo.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 9 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? 9 yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 9, 1922

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
9 8 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Robert Smith

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

12. MAIDEN NAME OF MOTHER Jessie Tanner

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

14. INFORMANT Keana Burns
 (Address) ISOLATION HOSPITAL

15. FILED AUG 13 1931 Mar C. Starker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-13-1931

17. HEREBY CERTIFY, That I attended deceased from Aug 6, 1931, to Aug 13, 1931 that I last saw him alive on Aug 13, 1931 and that death occurred, on the date stated above, at 1:00 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

tubercular Meningitis
24 24 10
 (duration) yrs. _____ mos. 11 ds.
 CONTRIBUTORY Besuchio pneumonia
 (SECONDARY) Secondary (duration) yrs. _____ mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED Home
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Sty. Culture, etc.
 (Signed) John Eschenbrenner, M. D.

(Address) ISOLATION 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 Valhalla Park DATE OF BURIAL 8-15-1931

20. UNDERTAKER Provoost and Co ADDRESS 3710 N. Grand

