

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City St. Louis (No.)

Registrations District No. 7911
Primary Registration District No. 1008
ISOLATION HOSPITAL

30028
File No.
Registered No. 9092 (Ward)

2. FULL NAME

Madras Yancey
(a) Residence. No. 3622 Colby St. 11 Ward.

Length of residence in city or town where death occurred 2 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) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-10-1915

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day,hrs. ormin.
	<u>16</u>	<u>9</u>	<u>5</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)..... Missouri
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Lan Yancey</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>
	12. MAIDEN NAME OF MOTHER <u>Clara Francis</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>

14. INFORMANT Leona Burns
(Address) ISOLATION HOSPITAL

15. FILED 26 1931 W. C. Hall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 25 1931

17. I HEREBY CERTIFY, That I attended deceased from Aug 22, 1931, to Aug 25, 1931 that I last saw h. 12 alive on Aug 25, 1931, and that death occurred, on the date stated above at 12:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis, Epidemic
18
108

CONTRIBUTORY (SECONDARY) Lobar Pneumonia
left (duration)..... yrs..... mos. 4 ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF.....
WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS Albert Lester Allen
(Signed) John Eschenbrenner, M. D.
, 1931 (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 Fredericktown Mo DATE OF BURIAL Aug 27 1931

20. UNDERTAKER Polmerick and Sons Grand ADDRESS 2217

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.

