

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

Do not use this space.
38924

1. PLACE OF DEATH

County Registration District No. **791**
Township Primary Registration District No. **1005P**
City **St. Louis** (No. **City Hospital**)

File No.
Registered No. **11033**
St. Ward)

13243

2. FULL NAME

(a) Residence, No. **5919 Clemens** St., **5** Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **Life** 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) **Unknown**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
abt 49

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Laborer**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Missouri**

MOTHER 13. NAME **James Cox**

14. BIRTHPLACE (CITY OR TOWN) **Illinois** (STATE OR COUNTRY)

15. MAIDEN NAME **Phoebe Belthaus**

16. BIRTHPLACE (CITY OR TOWN) **Illinois** (STATE OR COUNTRY)

17. INFORMANT **Hospital Information** (ADDRESS) **City Hospital**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Peter's** DATE **11/3** 1931

19. UNDERTAKER **Alexander & Sons** (ADDRESS) **617 S. Olive St.**

20. FILED **NOV -2 1931** **Wm. E. Starker** Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Nov. 1st 1931**

22. I HEREBY CERTIFY, That I attended deceased from **Oct. 30th 1931**, to **Nov. 1st 1931**. I last saw him alive on **Nov. 1st 1931**. Death is said to have occurred on the date stated above, at **7:20 A.M.**

The principal cause of death and related causes of importance were as follows:

Labar pneumonia
100/108
Date of onset

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? **clinical** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify **FN Thrombosis** (Signed) **City Hospital**, M. D.
(Address)

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.

Cox