

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

Do not use this space.

1. PLACE OF DEATH

County

Registration District No. **791**

Township

Primary Registration District No. **1003**

City **St. Louis Mo** (No. **City Hospital #2**)

File No. **3089**

Registered No. **819**

St. Ward)

2. FULL NAME

(a) Residence, No. **514 South 2nd St.**, **22** Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **27** 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 **Col** 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. or min.
abt 41 - - -

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **Laborer 237**
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ark 2**

13. NAME **unknown**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **unknown 31**

15. MAIDEN NAME **unknown**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **unknown 1**

17. INFORMANT (ADDRESS) **A Gertrude Creath City Hospital**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Washington D** DATE **1-16 1932**

19. UNDERTAKER (ADDRESS) **Walter Richters 3500 Outpost St**

20. FILED **Jan 25 1932** Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-14 1932**

22. I HEREBY CERTIFY, That I attended deceased from **1-2 1932** to **1-14 1932**

I last saw him alive on **1-14-32**, 19 **32** Death is said to have occurred on the date stated above, at **4:20** m.

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

73C
Chronic myocarditis
Other contributory causes of importance:
930

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **0** Date of injury _____, 19____
Where did injury occur? **0** (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 _____
(Signed) **W. Smith**, M. D.
(Address) **City Hospital #2**

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.

