

**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. *78*

Township.....

Primary Registration District No. *1000*

City *St. Louis Mo* (No. *St. Louis Mo*)

File No. *10229*

Registered No. *2248*

St. Ward

2. FULL NAME

(a) Residence. No. *Shaver*
(Usual place of abode)

St. *no. 12* Ward. *Shaver Mo*

Length of residence in city or town where death occurred yrs. mos. ds.

no ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 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 *Single*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 4-1876*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
50 3 4

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Dispatcher 128*
(b) General nature of industry, business, or establishment in which employed (or employer) *Trisco R.R.*
(c) Name of employer *Trisco R.R.*

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ind 2*

10. NAME OF FATHER *A.P. Gentry*

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

12. MAIDEN NAME OF MOTHER *Minnie Hooper*

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

14. INFORMANT *Mrs M. Gentry*
(Address) *Shaver Mo*

15. FILED *1-8-1932* *M. C. Starck* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-8-1932*

17. I HEREBY CERTIFY, That I attended deceased from *2-17-1932* to *3-7-1932* that I last saw him alive on *3-7-1932* and that death occurred, on the date stated above, at *1:00 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Liver
4 6 2 yrs. 2 mos. ds.

CONTRIBUTORY (SECONDARY) *none* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *1*
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *3-7-32*

19. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *operative finding*
(Signed) *P. Haines*, M. D.

3-8-1932 (Address) *4960 Faubld*

*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

Indianapolis Ind *Mar 8 1932*

20. UNDERTAKER *Emberson Ind Co* ADDRESS *4204*

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

