

**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 File No. 24598
 Township _____ Primary Registration District No. 20034 Registered No. 6737
 City St. Louis Mo. City Hospital St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 1509 1/2 Cass St. 15 Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 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) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 237
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Laborer
 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) Missouri 1

MOTHER 13. NAME Unknown

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 31

MOTHER 15. MAIDEN NAME Unknown

FATHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT A. Hyatt (ADDRESS) City Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE St Louis Ill DATE 7-18 1932

19. UNDERTAKER Walter Richter (ADDRESS) 3500 Rutger St

20. FILED 7-21 1932 Walter Richter Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-7 1932

22. I HEREBY CERTIFY, That I attended deceased from 7-4 1932 to 7-7 1932

I last saw him alive on 7-7 1932 Death is said to have occurred on the date stated above, at 11:15 m.

The principal cause of death and related causes of importance were as follows:
75B

Other contributory causes of importance:
Chronic Alcoholism

Name of operation _____ Date of _____
 What test confirmed diagnosis? Ch. Lab Was there an autopsy? No

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 _____

(Signed) C. M. Smith M. D.
 (Address) CITY HOSP. No. 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.

