

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

Do not use this space.

27650

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City *St. Louis Mo* (No. *City Hospital #2*) St. Ward)

File No.
Registered No. **7468**
St. Ward)

2. FULL NAME

(a) Residence, No. *1521 Cass* St., *26* Ward.

(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 <i>Male</i>	4. COLOR OR RACE <i>Col</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>1-8-1882</i>		
7. AGE	YEARS	MONTHS
	<i>50</i>	<i>6</i>
		<i>28</i>
		If LESS than 1 day, hrs. or min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missy*

MOTHER FATHER 13. NAME *Peter Sanders*

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

MOTHER 15. MAIDEN NAME *Unknown*

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

17. INFORMANT (ADDRESS) *A. J. ... City Hospital*

18. BURIAL, CREMATION, OR REMOVAL PLACE *father's grave* *8-16-1932*

19. UNDERTAKER (ADDRESS) *W. ...*

20. FILED *AUG 15 1932* Registrar

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-6-* 19*32*

22. I HEREBY CERTIFY, That I attended deceased from *7-31* 19*32* to *8-6-* 19*32*

I last saw him alive on *8-6-* 19*32* Death is said to have occurred on the date stated above, at *2:00* m.

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

131
Chronic myocarditis
132
Chronic nephritis

Other contributory causes of importance: *131*

Name of operation: *Chronic nephritis* Date of: *1932*

What test confirmed diagnosis? *Chronic* 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 *Chronic*

(Signed) *City Hospital* M. D.

(Address) *City Hospital*

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.

