

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

Do not use this space.

29282

1. PLACE OF DEATH

County Jackson
Township Frank
City St. Louis

Registration District No. 389

Primary Registration District No. 8008

File No. _____

Registered No. _____

St. 3155 Ward

2. FULL NAME

(a) Residence, No. 2440 Astor
(Usual place of abode)

St. 14 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rose Sanders

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 6 - 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 11 5

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Ladone

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 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) New York City

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT Rose Sanders
(ADDRESS) 2440 Astor

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Washgton DATE Sept 14 1932

19. UNDERTAKER Rose & Henselerson
(ADDRESS) 15 Jackson

20. FILED Sept 17 1932 M. M. Carome Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 11 1932

22. I HEREBY CERTIFY That I attended deceased from Sept 10 1932

I last saw him alive on _____, 19____. Death is said

to have occurred on the date stated above, at 51 m.

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

Acute peritonitis Date of onset 16 16 17

Other contributory causes of importance: (7)

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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) Charles H. Hays M. D.
(Address) St. Louis

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.

