

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

Do not use this space.

30973

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 11178
City St. Louis (No. City Hospital)

File No.
Registered No. 8694
St. Ward)

8632

2. FULL NAME

(a) Residence, No. 1068 Hodiamont St. 5 Ward. 5
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 10 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 white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 3-1853

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>78</u>	<u>9</u>	<u>24</u>	

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

12. BIRTHPLACE (CITY OR TOWN) Shipman (STATE OR COUNTRY) Illinois

13. NAME John Parker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) South Carolina

15. MAIDEN NAME Amanda Parks

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) South Carolina

17. INFORMANT (ADDRESS) Hospital information
City Hospital

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Matthew DATE 9/29, 1932

19. UNDERTAKER (ADDRESS) Ziegenfain Bros.
26 E. Cherokee St.

20. FILED SEP 21 1932 Mayl Parker Registrar.

5 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 27th, 1932

22. I HEREBY CERTIFY, That I attended deceased from Aug 22nd, 1932, to Sept. 27th, 1932
I last saw him alive on Sept. 27th, 1932 Death is said to have occurred on the date stated above, at 7:05 a.m.
The principal cause of death and related causes of importance were as follows:

LOBAR PNEUMONIA - BILATERAL BASES Date of onset 9/2
CHRONIC MYOCARDITIS
CHRONIC NEPHRITIS
137
108
108
Other contributory causes of importance:
SENILE DEMENTIA (1)

Name of operation SUPRAPUBIC PROSTATECTOMY Date of 9.15-32
What test confirmed diagnosis? Plaque test 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.....

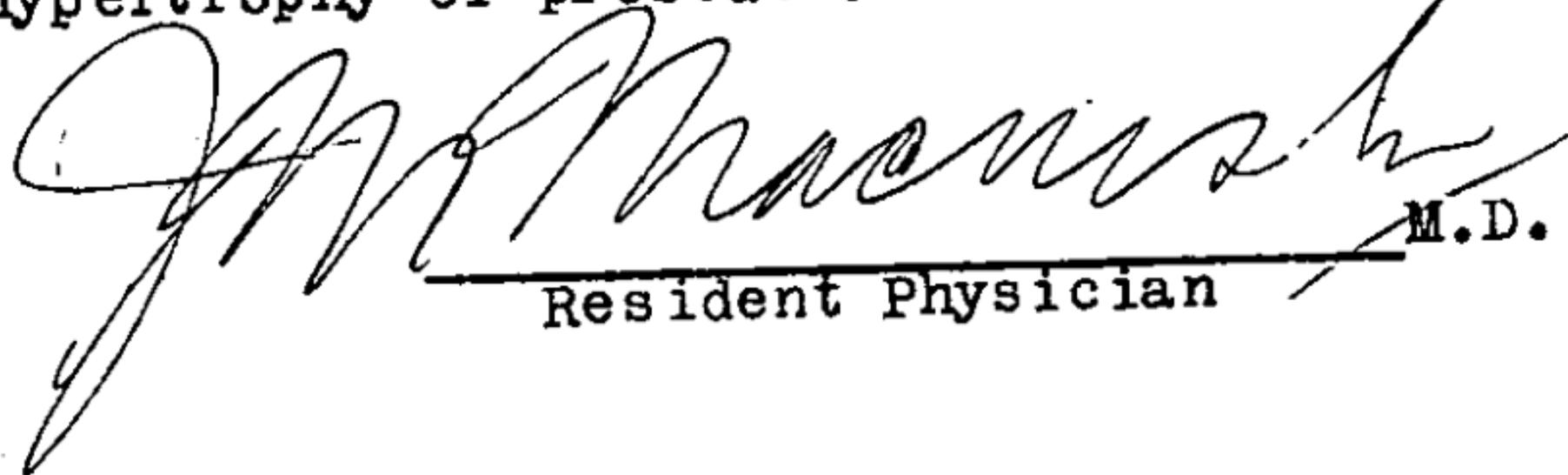
24. Was disease or injury in any way related to occupation of deceased?
If so, specify PH Macnish, M. D.
(Signed) City Hospital
(Address) City Hospital # 1.

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.

3-1-33

Benign hypertrophy of prostate.

A large, cursive handwritten signature in black ink, appearing to read "J. M. Brown". The signature is written over a horizontal line that underlines the printed text below it.

Resident Physician

M.D.

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

8694

Name:

Julius M. Quick

Who died at

St. Louis, Mo.

on

Sept. 27, 1932,

Residence: No. _____

St. _____

(If nonresident, city or town)

Length of residence in city or

town where death occurred: Years _____

Months _____

Days _____

Sex _____

Color or race _____

Single, married, widowed or divorced: _____

Date of birth _____

Age: Years _____

Months _____

Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____

Year _____

Birthplace (State or Country) _____

Birthplace of father (State or Country) _____

Birthplace of mother (State or Country) _____

Principal cause of death: _____

Lobar Pneumonia - Bilateral Basal - Chronic Myocarditis - Chronic Nephritis

Other contributory causes of importance _____

Senile Dementia

Name of operation _____

Supra Pubic Prostatectomy

What test confirmed diagnosis? _____

Was there an autopsy? _____

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 _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____