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.

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

Do not use this space.

31354

File No.

Registered No. 9761

1. PLACE OF DEATH

County ..... Registration District No. .....

Township ..... Primary Registration District No. .....

City St Louis Mo (No. City Hospital #2 St. ..... Ward)

2. FULL NAME William Dobson

(a) Residence, No. 916 So 13th St., 22 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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

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

7. AGE: abt. YEARS 60 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.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Laborer 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): Unknown 31

FATHER

13. NAME: Unknown

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 Gertrude Creath City Hospital #2

18. BURIAL, CREMATION, OR REMOVAL
PLACE Washington Park DATE Nov 6th 1932

19. UNDERTAKER (ADDRESS): A.L. Beal Und Co. 2726 Lucas Ave

20. FILED NOV - 4 1932 19 Max C. Parker Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10 - 30 , 1932

22. I HEREBY CERTIFY, That I attended deceased from 10 - 29 - , 1932, to 10 - 30 - , 1932

I last saw him alive on 10 - 30 - , 1932 Death is said to have occurred on the date stated above, at 9 P m.

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

Date of onset

82A

Cerebral Hemorrhage

Other contributory causes of importance: 82 (1)

Name of operation ..... Date of .....

What test confirmed diagnosis? Autopsy 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) C. M. Smith, M. D.

(Address) City Hospital #2