

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.

3684

1. PLACE OF DEATH
 County Registration District No. **791**
 Townshp. Primary Registration District No. **1013**
 City **St. Louis, Mo.** (No. **City Hospital 2**) St. Ward
 2. FULL NAME **Calvin Dozier**
 (a) Residence, No. **2719 Wash** St., **21** 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.

File No.
 Registered No. **639**
 St. Ward

PERSONAL AND STATISTICAL PARTICULARS
 3. SEX **male**
 4. COLOR OR RACE **Col**
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **single**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **6-2-1892**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
40 7 11
 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**
 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) **Mo**
 FATHER
 13. NAME **Calvin Dozier**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mo**
 MOTHER
 15. MAIDEN NAME **Pyper Adams**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mo**
 17. INFORMANT **a Gertrude Grant** (ADDRESS) **City Hosp # 2**
 18. BURIAL, CREMATION, OR REMOVAL **Jefferson Barracks** DATE **Jan 21** 19**33**
 19. UNDERTAKER **Dement - son** (ADDRESS) **2700 Wash St**
 20. FILED **JAN 18 1933** **May C Stanley** Registrar.

MEDICAL CERTIFICATE OF DEATH
 21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-13-33**
 22. I HEREBY CERTIFY, That I attended deceased from **1-12-33** to **1-13-33**, 19**33**
 I last saw him alive on **1-13-33**, 19**33** Death is said to have occurred on the date stated above, at **7** m.
 The principal cause of death and related causes of importance were as follows:
463
463
Cancer of Stomach Primary seat.
 Other contributory causes of importance:
Cancer of Liver
 Name of operation **463** 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 **Cancer**
 (Signed) **Candmith** M. D.
 (Address) **City Hosp # 2**

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