

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

Do not use this space.

7524

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No.....
Primary Registration District No.....
(No. *Beaconess Hospital*)

File No.....
Registered No. **1480**
St. Ward)

2. FULL NAME

Irindell H. Whaley

(a) Residence, No. *925 Belmont* St. *58* Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* | 4. COLOR OR RACE *White* | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept. 5 - 1912*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
20 5 6

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

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

13. NAME *Arch Whaley*

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

15. MAIDEN NAME *Edith Whaley*

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

17. INFORMANT (ADDRESS) *Edith Whaley 925 Belmont*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Parsonage* DATE *July 15 1933*

19. UNDERTAKER (ADDRESS) *Cullinan Bros 1714 Grand Blvd*

20. FILED *FEE 13 1933* *Max C. Parker Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 11 1933*

22. I HEREBY CERTIFY, That I attended deceased from *Feb 1 1933* to *Feb 11 1933*

I last saw him alive on *Feb 10 1933* Death is said to have occurred on the date stated above, at *29* m.

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

Subacute Meningitis
24A 24
Other contributory causes of importance:

Date of onset *about Jan 28*

Name of operation..... Date of.....
What test confirmed diagnosis? *Spinal puncture* 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? *No*
If so, specify.....

(Signed) *Kelaud B. Alford*, M. D.
(Address) *Beaumont Bldg*

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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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Dr Alfred
Beunour Bldg