

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

Do not use this space.

7597

**1. PLACE OF DEATH**

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City *St. Louis* (No. *City Hospital*)

File No.....

Registered No. **1553**

St. .... Ward)

**2. FULL NAME**

(a) Residence, No. .... St. .... Ward.

(Usual place of abode) *204 N. 14th St.* (If nonresident, give city or town and State)

Length of residence in city or town where death occurred *51* 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) *married*

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
*abt. 70* *Unk.* *Unk.*

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

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

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) *Kentucky*

13. NAME *Geo. Traplin*

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

15. MAIDEN NAME *Marie Unknown*

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

17. INFORMANT (ADDRESS) *Hospital information City Hospital*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Washington Park* DATE *Feb 16* 19*33*

19. UNDERTAKER (ADDRESS) *C. J. Kates 4107 Sunningway*

20. FILED **FEB 14 1933** *Max Starke* Registrar.

**4 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb. 12th* 19*33*

22. I HEREBY CERTIFY, That I attended deceased from *Feb 2nd* 19*33* to *Feb. 12th* 19*33*

I last saw him alive on *Feb. 12th* 19*33* Death is said to have occurred on the date stated above, at *7:05 P.M.*

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

*Chd. Myocarditis*  
*9:30*  
*10:15*  
*1:30 P.M.*

Other contributory causes of importance:  
*Broncho-pneumonia*  
*Acute urinary retention*  
*due to chd. with structural changes*

Name of operation *none* Date of operation *at unknown*

What test confirmed diagnosis? *General* 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) *Maurice G. Miller* M. D.

(Address) *City Hospital*

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.

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