

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

Do not use this space.

25253

**1. PLACE OF DEATH**

County..... Registration District No. 7471  
Township..... Primary Registration District No. 302  
City St. Louis (No. City Hospital)

File No. ....  
Registered No. 6729  
St. .... Ward)

**2. FULL NAME**

(a) Residence, No. 3020 N. 14th 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.

**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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 25 - 33

7. AGE YEARS MONTHS DAYS If LESS than 1 day, # hrs. or # min.

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.  
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) St. Louis Mo

13. NAME Pearl Clark

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Reynolds Co Mo

15. MAIDEN NAME Belle ?

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Reynolds Co Mo

17. INFORMANT (ADDRESS) Dr. J. M. Keel City Hospital #1

18. BURIAL, CREMATION, OR REMOVAL PLACE Cremation DATE 8-2-33

19. UNDERTAKER (ADDRESS) W. P. Richardson City Hospital

20. FILED 1933 J. F. Brebeck Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 25, 19 33

22. I HEREBY CERTIFY That I attended deceased from 7-25, 19 33 to 7-25, 19 33

I last saw him alive on 7-25, 19 33 Death is said to have occurred on the date stated above, at 9:45 a.m.

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

Premature infant

159 159

Other contributory causes of importance

Date of onset

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

What test confirmed diagnosis?..... 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) Lewis Ent, M. D.  
(Address) City Hospital

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.

SEP 20 1933

