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

Do not use this space.

File No. 31744
Registered No. 8474

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 3

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

2. FULL NAME Charles Nelson

(a) Residence, No. 1012 N 14th St., 25 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 8 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) 4-27-1899

7. AGE: Years 34 | Months 4 | Days 16 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 28
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) Illinois

FATHER

13. NAME Charles Nelson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER

15. MAIDEN NAME Josephine Brown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

17. INFORMANT (ADDRESS) Mr. Gertrude Heath City Hospital #2

18. BURIAL, CREMATION, OR REMOVAL
PLACE St Louis M. DATE 9-15 1933

19. UNDERTAKER: Walter Richter
(ADDRESS) 3500 Butler St

20. FILED OCT 20 1933 19 J H Bredeck
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-13 1933

22. I HEREBY CERTIFY, That I attended deceased from 9-10- 1933, to 9-13- 1933

I last saw him alive on 9-13- 1933. Death is said to have occurred on the date stated above, at 4 a.m.

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

	Date of onset
105	
Lobar Pneumonia 108	
Other contributory causes of importance:	

Name of operation ..... Date of .....
What test confirmed diagnosis? Clin Dx 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? .....
If so, specify .....
(Signed) R. Smith M. D.
(Address) City Hospital #2

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

OCT 20 1933