

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.

AN 28 1934

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

Do not use this space.

41667

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **003**
City..... **St. Louis** (No. **Isolation Hospital**)

File No.....
Registered No. **40689** St. Ward)

2. FULL NAME

(s) Residence, No. **541 Kirkham Ave** St. **Webster Groves Mo.**
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. **12 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**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **October 14-1931**
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
2 1 28

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Child**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **At Home**
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) **Webster Groves Missouri**

13. NAME **Clarence W. Ross**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **San Antonio Texas**

15. MAIDEN NAME **Elsie Picker**

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

17. INFORMANT (ADDRESS) **Clarence W. Ross 571 Kirkham Webster Groves Mo**

18. BURIAL, CREMATION, OR REMOVAL PLACE **New Pickers** DATE **Dec. 14 33**

19. UNDERTAKER (ADDRESS) **H. W. McLaughlin 1612 Washington Ave**

20. FILED **DEC 15 1933 J. B. Beck Registrar.**

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **12-12-1933**

22. I HEREBY CERTIFY, That I attended deceased from **12-1-33** to **12-12-1933**
I last saw him alive on **Dec 12 48**, 19**33** Death is said to have occurred on the date stated above, at **2:45 AM**.
The principal cause of death and related causes of importance were as follows:

Muscles of Bronchopneumonia
Date of onset **11-25**
Other contributory causes of importance: **St. Media Pulmon**

Name of operation **None** Date of operation.....
What test confirmed diagnosis **Clinical** 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? **No** 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) **John Eschenbrenner M. D.**
(Address) **ISOLATION HOSPITAL**

