

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

41668

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **303**

City.....

(No. **City Hosp.**)

File No.

Registered No. **10690**

St.

Ward)

2. FULL NAME

(a) Residence, No. **1509 Chouteau**

(Usual place of abode)

St., **rv**

Ward.

(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 **2** 4. COLOR OR RACE **20** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Wm Byrd**6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Jul 31 - 1905**7. AGE YEARS **28** MONTHS **10** DAYS **11** If LESS than 1 day, ... hrs. or min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Wm Byrd**9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **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) **Arkansas**13. NAME **Frank Martin**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Arkansas**15. MAIDEN NAME **Rose (Unknown)**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mo**17. INFORMANT **Wm Byrd, City Hosp**

18. BURIAL, CREMATION, OR REMOVAL

PLACE **New St. Marcus**DATE **Dec 15**

1935

19. UNDERTAKER **D W M Laughlin**(ADDRESS) **1631 Mission Ave**20. FILED **DEC 16 1935**

19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Dec 12**, 19**35**22. I HEREBY CERTIFY, That I attended deceased from **12/18**, 19**35**, to **12/12**, 19**35**I last saw him alive on **12/12**, 19**35**. Death is saidto have occurred on the date stated above, at **6:30** a.m.

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

Date of onset **12/11/35**Other contributory causes of importance: **Pneumonia, labor**Name of operation **108** Date of **12/11/35**What test confirmed diagnosis? **108** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? **No** Date of injury

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 **denial sent**(Signed) **City Hosp**, M. D.(Address) **City Hosp**

