

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.

MAR 24 1934

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis, Mo.* (No.)

Registration District No.....
Primary Registration District No..... **1003**

6897
File No.....
Registered No. **1757**
St. Ward)

2. FULL NAME

William Smith

(a) Residence, No. *2102 Penn. Delaware* St., *21* Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *4 1/2* 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 *Colored* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *---*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 16, 1931*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
2 4 29

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

FATHER 13. NAME *Charles Smith*

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

MOTHER 15. MAIDEN NAME *Elovene Mitchell*

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

17. INFORMANT *Thas Barras* (ADDRESS) *5601 Arsenal St.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *City Cemetery* DATE *Feb 20, 1934*

19. UNDERTAKER *W. H. ...* (ADDRESS) *5800 ...*

20. FILED *J. B. Bredeck* 19 *34* Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 14, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *Feb 8, 1934* to *Feb 14, 1934*

I last saw her alive on *Feb 14, 1934* Death is said to have occurred on the date stated above, at *3:30 p.m.*

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

Measles 7 Date of onset *2-3*

Bronchopneumonia 10-26

Other contributory causes of importance

Name of operation *No Clinical* Date of *...*

What test confirmed diagnosis? *Clinical* Was there an autopsy? *Yes*

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) *John Schreber* M. D. Address *...*

ISOLATION HOSPITAL

