

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

Do not use this space.

15218

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Registration District No. **1003**

Registered No. **4333**

City **St. Louis** (No. **1110**)

Ward **6** (Name **Mo. Baptist Sanitarium**)

2. FULL NAME

(a) Residence, No. **24967 Leticia** St. **6** Ward.

(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) **Nov 24 1908**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	25	4	2	

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

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 **John J. Byrne**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo.**

15. MAIDEN NAME **Margaret Scanlon**

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

17. INFORMANT (ADDRESS) **John J. Byrne 24967 Leticia**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Cabourp** DATE **Dec 30 1934**

19. UNDERTAKER (ADDRESS) **Cullen R. Kelly 1716 N. 1st St. St. Louis**

20. FILED **1934** REGISTRAR **J. J. Redick**

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4-26-1934**

22. I HEREBY CERTIFY, That I attended deceased from **July**, 19**24**, to **Apr. 26**, 19**34**. I last saw him alive on **Apr 26**, 19**34**. Death is said to have occurred on the date stated above, at **10:00 pm**.

The principal cause of death and related causes of importance were as follows: **Memoria Feb. 1934**

Chronic nephritis

Other contributory causes of importance: **Special Injury with Proliferation of Blood in Section Injury occurred 7 mo before patient's death**

Name of operation **Prostatectomy**

What test confirmed diagnosis? **N.P.H.T.** 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? **no.** If so, specify (Signed) **A. E. Witt** M. D. (Address) **958 Brederley**

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Gullon P. Hill
T.R. 2425

De W. Hill
Hill
W. Hill

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1093
 City St. Louis (No. Mo Baptist Parish) St. _____ Ward _____
 File No. _____
 Registered No. 4333

2. FULL NAME

(a) Residence, No. _____ St. _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 26, 1934

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

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h..... alive on _____, 19____. Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

to have occurred on the _____ above, at _____ m.

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

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

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

Other contributory causes of importance

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19____

19. UNDERTAKER (ADDRESS)

20. FILED 9-5-34 19____ J F Bredeck Registrar.

SUPPLEMENTARY
1862
Personal Injury
Injury occurred 7 yrs ago
 Date of onset 14

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? Accident Date of injury, _____, 19____.

Where did injury occur? Camp Rest - Louisville, Kentucky
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Recreation Office Training Camp

Manner of injury. Spel from observation stand

Nature of injury. Compens. Fracture of humerus spine

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) A E Velt M. D.

(Address) 958 Arsenal Bldg

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

NEW YORK STATE BOARD OF HEALTH IS VERY IMPORTANT

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