

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.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis*

(No. *2945* *Laurel Ave.* City *Hosp #2* Ward)

File No. **22209**

Registered No. **5985**

2. FULL NAME

(a) Residence, No. *2727*

(Usual place of abode)

*Walnut St. 22*

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *15* 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

*negro*

5. SINGLE, MARRIED, WIDOWED, OR  
DIVORCED (Write the word)

*in*

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

*Rosa Byrd*

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

*1/17/1877*

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1  
day, ..... hrs.  
or ..... min.

*57*

*4*

*28*

OCCUPATION

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

*tail*

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)

*Pa.*

13. NAME

*Warren Byrd*

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

*Pa.*

15. MAIDEN NAME

*Annice ?*

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

*Pa.*

17. INFORMANT  
(ADDRESS)

*Ester May Shepard  
2945 Laurel Ave. #2*

18. BURIAL, CREMATION, OR REMOVAL

PLACE

*Lathrop Dickson*

DATE

*June 18, 1934*

19. UNDERTAKER  
(ADDRESS)

*English and Co  
2945 Laurel Ave.*

20. FILED

*18 1934*

19

Registrar.

MEDICAL CERTIFICATE OF DEATH

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

*6/15/1934*

22. I HEREBY CERTIFY, That I attended deceased from

*6/19*

*1934*

to *6/15*

*1934*

I last saw him alive on *6/15/34*, 19..... Death is said

to have occurred on the date stated above, at *6:10 a.m.*

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

*Chronic Nephritis  
with Uremia*

Date of onset

*6/9/34*

Other contributory causes of importance:

*10. Hypertension*

Name of operation.....

Date of.....

What test confirmed diagnosis? *clinical*

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) *Henry P. Hampton*

M. D.

(Address) *2945 Laurel Ave*

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