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.

OCT 11 1934

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

Do not use this space.

34634

File No.

Registered No. 9463

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH

County

Township

City St Louis (No. City Hospital St. Ward)

8791

2. FULL NAME Baby Renton

(a) Residence, No. 1217 Marison 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

3. SEX M.

4. COLOR OR RACE W

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) Aug 24-34

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
0	0	14	

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 Lawrence Renton

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

MOTHER

15. MAIDEN NAME Jennie

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

17. INFORMANT Mrs. Lyle M. Lee (ADDRESS) City Hospital

18. BURIAL, CREMATION, OR REMOVAL
PLACE City Field DATE 9-28-34, 19

19. UNDERTAKER David Low Funeral Home #1
(ADDRESS) St. Louis

20. FILED SEP 26 1934, 19 J. J. Bredeick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 7, 1934

22. I HEREBY CERTIFY, That I attended deceased from 8/24, 1934, to 9/7, 1934

I last saw h. alive on 9/7, 1934. Death is said to have occurred on the date stated above, at 8:45 a.m.

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

	Date of onset
Bronchopneumonia	
10 days	

Other contributory causes of importance:

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? 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) A. E. Shrad, M. D.

(Address)

#2

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

St Louis City

9463

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: (Baby) Renton

Who died at City Hosp #1 on Sept 7 - 1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W Single, ~~married, widowed or divorced~~: _____

Date of birth _____ Age: Years 0 Months 0 Days 14

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Bronchopneumonia

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) No other complications

Birthplace of mother (State or country) _____

Principal cause of death: _____

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician D. B. Elrod

Address of physician _____

Signature of Registrar J. F. Bredeck **Date filed** Nov 2 - 34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh
State Registrar

Reg. Dist. No.
Primary Reg. Dist. No.

Special Agent.