

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

Do not use this space.

10207

1. PLACE OF DEATH

County Jackson
Township Jefferson
City St. Louis Mo.

Registration District No. 709
Primary Registration District No. 629, 5938

File No. _____
Registered No. _____
St. _____ Ward)

2. FULL NAME

(a) Residence, Not _____ 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 fm 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Seward Wheeler

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 15, 1901

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
33 6 21

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.

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

13. NAME Alex Marsh

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

15. MAIDEN NAME Elizabeth Evans

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

17. INFORMANT (ADDRESS) Seward Wheeler
St. Louis

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE St. Louis 3/8 35

19. UNDERTAKER (ADDRESS) J. R. Luckey, M.D.
Wheatland, Mo.

20. FILED March 19, 1935 Veda Underacker
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 6, 1935

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
I last saw him alive on March 3-6-35, 1935. Death is said to have occurred on the date stated above, at 10:00 a m.

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

Death was caused from Tuberculosis of Lungs.
Other contributory causes of importance: 2 years ago.

Name of operation none Date of _____
What test confirmed diagnosis? X-ray 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 _____, 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) Dr. M. L. McClorcken P. D.
(Address) St. Louis, Mo.

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.

