

APR 29 1935

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

Do not use this space.

14293

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City *St. Louis* (No. *City Hosp #1*)

File No. _____
Registered No. **3108**
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. *1402 1/2 Compton* St. *Ward 18*

Length of residence in city or town where death occurred *76* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

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) *Dec 1 - 1858*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 4 2

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

MOTHER FATHER
13. NAME *John Stewart*

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

15. MAIDEN NAME *Anderson*

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

17. INFORMANT (ADDRESS) *Hosp City Hosp #1*

18. BURIAL, CREMATION, OR REMOVAL PLACE *New St. Marcus* DATE *4-6* 1935

19. UNDERTAKER (ADDRESS) *A. Ellis 3240 Delmar Ave*

20. FILED *APR -4 1935* *J. B. Beck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4/3*, 19*35*
22. I HEREBY CERTIFY, That I attended deceased from *4/1*, 19*35*, to *4/3*, 19*35*.
I last saw him alive on *4/3*, 19*35*. Death is said to have occurred on the date stated above, at *6:30* pm.
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
Date of onset _____

Other contributory causes of importance: *J. J. A.*

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) *W. L. Harris* M. D.
(Address) *City Hosp #1*

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.

