

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

Do not use this space.

MAY 13 1935

15029

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.....

Township.....

Primary Registration District No. **1003**

Registered No. **3911**

City *St. Louis* (No. *71167*)

City *St. Louis*

St. *Ward* (Ward)

2. FULL NAME

(a) Residence, No. *City Hospital No. I* St. *23* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *16* 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 *Wh* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widower*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 21, 1863*

7. AGE YEARS *71* MONTHS *7* DAYS *27* If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Elevator repair*  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *City Hosp.*  
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) *Massachusetts*

FATHER 13. NAME *Not known*

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

MOTHER 15. MAIDEN NAME *Not known*

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

17. INFORMANT (ADDRESS) *St. Louis City Hospital*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Willow Springs* DATE *Apr. 30* 1935

19. UNDERTAKER (ADDRESS) *W. H. Bergman & Son*

20. FILED *APR 29 1935* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4/28*, 19*35*

22. I HEREBY CERTIFY, That I attended deceased from *4/22*, 19*35*, to *4/28*, 19*35*

I last saw *him* alive on *4/28*, 19*35*. Death is said

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

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

*Coronary Occlusion*  
Other contributory causes of importance: *B*

Name of operation *Thrombectomy* Date of.....  
What test confirmed diagnosis?..... Was there an autopsy? *yes*

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. H. McCain*, M. D.  
(Address) *City Hosp*

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.

