

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.

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

Do not use this space.

34485

1. PLACE OF DEATH

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

File No.
Registered No. **8926**
St. Ward)

2. FULL NAME

(a) Residence, No. **1110ⁿ Channing**, **21** 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 **Male** 4. COLOR OR RACE **Colored** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **married**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Dec. 14 - 1890**

7. AGE YEARS **44** MONTHS **10** DAYS **7** If LESS than 1 day, hrs. or min.

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

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) **Waltham Miss.**

13. NAME **Walter Abbott**

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

15. MAIDEN NAME **Unknown**

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

17. INFORMANT **Beulah Abbott** (ADDRESS) **1110ⁿ Channing**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Father Dickson** DATE **Oct. 26**, 1935

19. UNDERTAKER **Thel M. Tyler** (ADDRESS) **3029 Cambridge**

20. FILED **25** 1935, 19 **J. F. Bredeck** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct 21**, 1935

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw him alive on 19..... Death is said to have occurred on the date stated above, at **6¹⁵** A. M.

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

cerebral apoplexy Date of onset

Other contributory causes of importance: **82**

Name of operation 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) **Harold Palmer** M. D.
W. J. Gifford (Address) **10/22/35**

