

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.

JAN 13 1936

41385

1. PLACE OF DEATH

County.....  
Township.....  
City *St. Louis* (No. *Swiss Hospital*)

Registration District No. *791*  
Primary Registration District No. *1003*

File No.....  
Registered No. *10607*  
St. *10607* (Ward)

2. FULL NAME

*Albert S. Andrews*  
(a) Residence, No. *817 Burke, Gonzales, Ark. RR*  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *19* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 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) *February 1893*

7. AGE YEARS MONTHS DAYS if LESS than 1 day, .....hrs. or .....min. *42*

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Railroad*

10. Date deceased last worked at this occupation (month and year) *11-15-35* 11. Total time (years) spent in this occupation *12 yrs*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Alabama*

13. NAME *J. Y. Andrews*

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

15. MAIDEN NAME *Mollie Jones*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *North Carolina*

17. INFORMANT (ADDRESS) *Hospital record*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Hager, Mo.* DATE *12-16-35*

19. UNDERTAKER (ADDRESS) *W. J. Humbert*

20. FILED *DEC 1 1935* *J. F. Bredeck* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12-15*, 19*35*

22. I HEREBY CERTIFY, That I attended deceased from *11-27*, 19*35*, to *12-15*, 19*35*

I last saw him alive on *12-15*, 19*35*. Death is said to have occurred on the date stated above, at *7:30* p.m.

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

*acute nephritis* Date of onset

Other contributory causes of importance: *MI, Myocarditis & cirrhosis liver*

Name of operation *none* Date of

What test confirmed diagnosis? Was there an autopsy? *no*

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? *no*

If so, specify

(Signed) *W. J. Macoy*, M. D.

(Address) *4960 Laclede, St. Louis, Mo.*

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