

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.

MAY 7 1936

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis mo* (No. *Barnes Hospital*)

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

File No. **17117**
Registered No. **3872**
St. _____ Ward _____

2. FULL NAME *George Frank Black*

(a) Residence, No. _____ St. *H R* Ward. *St. Jacob Ill*

(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 *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct. 4th 1879*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
56 6 4

OCCUPATION
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. *Farmer*
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) *St. Jacob Ill*

MOTHER FATHER
13. NAME *John Black*

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

15. MAIDEN NAME *Sarah Jane Tindley*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Jacob Ill*

17. INFORMANT (ADDRESS) *Anna Black St. Jacob Ill*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Jacob Ill* DATE *April 12th 1936*

19. UNDERTAKER (ADDRESS) *Albert H. Kopp Inc 429 North Euclid*

20. FILED **APR 8 1936** *J. Bredeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4-8-1936*

22. I HEREBY CERTIFY, That I attended deceased from *4-4-1936*, to *4-8-1936*

I last saw him alive on *4-8-1936*. Death is said to have occurred on the date stated above, at *9:30 a.m.*

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

Lobar Pneumonia + Heart Disease Date of onset *4-4-36*

Other contributory causes of importance: *Cerebral thrombosis - gaiter*

Name of operation _____ Date of _____
What test confirmed diagnosis? *Autopsy* 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) *M. E. Kerner & Walter H.* _____, M. D.
(Address) *Barnes Hospital*

