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.

ISOLATION HOSPITAL

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 3793

Township ..... Primary Registration District No. 1003 Registered No. 738

City Saint Louis, Mo. (No. Isolation Hospital St. ..... Ward)

96
86
0

2. FULL NAME William Kendrick

(a) Residence, No. 3619 Lierman St., 1 Ward. 15 1
(Usual place of abode) (If nonresident, give city or town and State)

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

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) |
|---|---|---|
| Male | White | Single |

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 29, 1897

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 39 | 9 | 18 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Roofer 95

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) St. Louis Mo. 1

FATHER

13. NAME James Kendrick

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri 1

MOTHER

15. MAIDEN NAME Nellie Dunn

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri 1

17. INFORMANT (ADDRESS) MG. Barry

18. BURIAL, CREMATION, OR REMOVAL

PLACE National DATE 1-20, 1937

19. UNDERTAKER (ADDRESS) Oscar J. Hoffmeister 4016 Chippewa Str

20. FILED JAN 18 1937, 19 J F Bredeck Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 16, 1937

22. I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1937, to Jan. 16, 1937. I last saw him alive on Jan. 16, 1937. Death is said to have occurred on the date stated above, at 8:30 p.m.

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

| | Date of onset |
|---|---|
| Meningococcic Meningitis | 1-8-37 |
| Bronchopneumonia | 1-11-37 |

18

Other contributory causes of importance:

Name of operation none Date of .....

What test confirmed diagnosis? clinical + laboratory 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) [signature] 1, M. D.

(Address) 5600 [illegible]

738