

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

Do not use this space.

JUL 8 - 1937

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22517

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

(No.....)

En Route City Hospital # 1 St. (Ward)

File No.....

Registered No. **6269**

2. FULL NAME

(a) Residence, No. *Unknown* St. *X* Ward. *1*
(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) *Unknown*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Unknown*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
about 45 *—* *—* *—* *—*

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

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) *Unknown*

13. NAME *Unknown*

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

15. MAIDEN NAME *Unknown*

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

17. INFORMANT (ADDRESS) *City Hospital # 1*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Washington* DATE *6-24-37*

19. UNDERTAKER (ADDRESS) *W. R. ...*

20. FILED **JUN 28 1937** *J. H. Bredebeck* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5/23/37*

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

I last saw h..... alive on _____, 19____. Death is said

to have occurred on the date stated above, at *3:30* p.m.

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

*Acute Hemorrhage
Chronic Ulcer of Pylorus
Oedema of Brain*

Other contributory causes of importance:

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 *See above*

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify.....

(Signed) *Joseph M. Quinn*

(Address) *City Hospital # 1*

CAUSE OF DEATH IN plain terms, so that it may be properly classified. - Exact statement of OCCUPATION is very important.

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