

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.

AUG 30 1937

1. PLACE OF DEATH

County St. Louis  
Township Carondelet  
City Koch

Registration District No. 1123

Primary Registration District No. 6248B

File No. 28391

Registered No. 314

(No. Koch. Hosp.)

St. \_\_\_\_\_

Ward \_\_\_\_\_

2. FULL NAME AUBREY CURTIS

(a) Residence, No. 3230 Pine Street St. \_\_\_\_\_ 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.

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 Negro  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sophie Curtis (Nee Speed)  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-10-1907  
7. AGE YEARS 37 MONTHS 30 DAYS 1 If LESS than 1 day, .....hrs. or .....min. 21

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer  
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) Kentucky

FATHER  
13. NAME Will Curtis

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

MOTHER  
15. MAIDEN NAME Maggie Johnson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Koch Hospital Records Koch, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Fulton Ky DATE Aug 5 1937

19. UNDERTAKER (ADDRESS) Watson Son 2769 Chouteau

20. FILED Aug 4 1937 L. Mowry Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 31, 1937

I HEREBY CERTIFY, That I attended deceased from 7-23-37 to 7-31-37

I last saw him alive on 7-31-37, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 8:00pm.

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

Chronic Pulmonary Tuberculosis Date of onset 1935

(Massive Hemoptysis)

Other contributory causes of importance: Tuberculosis of Larynx

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? X-Ray and sputum 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) Paul Murphy, M. D.

(Address) Koch Hospital Koch, Mo.

