LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

6485

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

1. PLACE OF DEATH
County St Louis Registration District No. 791 File No. 1696
Township Primary Registration District No. 1003 Registered No.
City ~~Albert~~ (No. 4401 Forest Park St. Ward)

2. FULL NAME Albert Daniels
(a) Residence. No. 4401 Forest Park St. 19 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. 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): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 14-1877

7. AGE: Years 49 Months 6. Days 3 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Chief Clerk To
(b) General nature of industry, business, or establishment in which employed (or employer): Asst-Traffic Mgr
(c) Name of employer: Big 4 R.R.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Cincinnatti Ohio

PARENTS
10. NAME OF FATHER: John Daniels
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio
12. MAIDEN NAME OF MOTHER: Mary Doyle
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio

14. INFORMANT: Mrs Ada Daniels
(Address) 4401 Forest Park

15. FILED ___ 19__ Max C Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 17 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1926, to Feb 17, 1927, that I last saw him alive on Jan 31, 1927, and that death occurred, on the date stated above, at 7.15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Phthisis pulmonalis
T B A
(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS? T.B. found.
(Signed) Nelson J Hawley, M.D
Feb 18, 1927 (Address) 5321 Easton av

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Cincinnatti Ohio
DATE OF BURIAL: 2/20 1927

20. UNDERTAKER: C.R. Lupton and Sons
ADDRESS: 4449 Olive St

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.

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... 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. 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)

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....:, 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m..

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

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20. UNDERTAKER	ADDRESS