

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

Do not use this space.

17064

1. PLACE OF DEATH

County.....
Towship.....
City..... *St. Louis*

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

File No.....
Registered No. **5028**
St. Ward)

2. FULL NAME

Clay Black
(a) Residence. No. *5351 Delmar* St., *12* 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. da. 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 22 - 1848*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hr. or _____ min.	
				<i>79</i>	<i>0</i>

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *(Retired) Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Black Hawk* (STATE OR COUNTRY) *Iowa*

10. NAME OF FATHER *Archibald Black*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Don't know* (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Lucinda Johnson*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Don't know* (STATE OR COUNTRY)

14. INFORMANT *Hilsmath Haller* (Address) *4351 Delmar Blvd.*

15. MAY 29 1921 FILED *May 6 Starckoff*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 29 1927*

17. I HEREBY CERTIFY, That I attended deceased from *May 24*, 1927, to *May 29*, 1927, that I last saw him alive on *May 28*, 1927, and that death occurred, on the date stated above, at *1:00 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterio Sclerosis

117A CONTRIBUTORY (SECONDARY) *11102* (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *D. J. ...*, M. D.

5729, 1927 (Address) *Lily ...*

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Memphis Mo *5729* 1927

20. UNDERTAKER

ADDRESS

W. Karanow 6175 Delmar

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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

