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

Do not use this space.

25931

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 7547

City St Louis (No. City Hospital St. ..... Ward)

6483

2. FULL NAME Charles Chilcott

(a) Residence. No. 1842 Fallon St., 25 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 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	Lohity	

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 4 1927

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
			17	

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) St Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER [illegible]

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

12. MAIDEN NAME OF MOTHER Ruth Chilcott

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

14. INFORMANT Hospital Information
(Address) Ackman City Hospital

15. FILED AUG 24 1927 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 21 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 17, 1927, to Aug 21, 1927 that I last saw him alive on Aug 21, 1927, and that death occurred, on the date stated above, at 7:15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastro-enteritis

11 A B

10 A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Broncho pneumonia

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1138

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

8/27, 1927 (Signed) [illegible], M. D
(Address) City Hospital

*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
Calvary Cem.	Aug 24 1927

20. UNDERTAKER	ADDRESS
Central Und Co	1841 Cass

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

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

Township..... Primary Registration District No..... Registered No. 7547

City..... (No. City Hosp. .....St. .....Ward)

2. FULL NAME Charles Chilcott

(a) Residence. No. 1842 O'Fallon .....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 M

4. COLOR OR RACE W

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) June 4/27

7. AGE YEARS | MONTHS 2 | DAYS 17 | 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) St. Louis
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Frank Chilcott

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

12. MAIDEN NAME OF MOTHER Ruth Allen

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

14. INFORMANT .....
(Address)

15. FILED OCT 15 1927, 19.. Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 21 1927

17. 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.

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

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

S-25931