

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

Do not use this space.

29198

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **City Hospital**)

File No. **18805**
Registered No. **18805**
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. **715 Lafayette St.** **23** Ward. (if nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred **4** yrs. **4** mos. **da.** How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 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) **May 19 - 1907**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	4		11	

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) **Merion**
(STATE OR COUNTRY)

10. NAME OF FATHER **Edgar Peter**

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

12. MAIDEN NAME OF MOTHER **Louise Edgar**

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

14. INFORMANT **Edman**
(Address) **City Hospital**

15. FILED **OCT - 3, 1927** **Maule Starke**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 30 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Sept 28 1927** to **Sept 30 1927** that I last saw **him** alive on **Sept 30, 1927**, and that death occurred, on the date stated above, at **9:55 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute enteritis
Typhoid
11913
1075A (duration) yrs. mos. da.
CONTRIBUTORY **Broncho-pneumonia**
(SECONDARY)
Secondary (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

109 (Signed) **Edmund R. Sheridan**, M. D.
11 (Address) **City Hospital**

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION OR REMOVAL **St. Peter's Home Care** DATE OF BURIAL **Oct 3 1927**

20. UNDERTAKER **M. Lang Klein 1631 Mo. Ave**
ADDRESS

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.

Putney.