

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

Do not use this space.

31822

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **City Hospital #2**) St. Ward.....

File No.
 Registered No. **9180**
 St. Ward.....

2. FULL NAME

Callahan Saunders
 (a) Residence. No. **1933 St Charles** St., Ward.....
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred **10** 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 **not known**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 9th 1900**

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.
27 **5** **3**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **porter**
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer **not known**

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

10. NAME OF FATHER **Horace Saunders**

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

12. MAIDEN NAME OF MOTHER **Henrietta Jackson**

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

14. INFORMANT (Address) **Anna F. Woodard**
City Hospital #2

15. FILED **OCT 15 1927** **Max G Starckoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct. 12th 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Aug. 10th**, 1927, to **Oct. 12th**, 1927 that I last saw h. **in** alive on **Oct. 12th**, 1927, and that death occurred, on the date stated above, at **5:05 P. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

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

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? **not known**

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **Clinical & X-ray**
 (Signed) **W. L. Drake**, M. D.

, 19 (Address) **City Hospital #2**

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Greenwood** DATE OF BURIAL **Oct 15 1927**

20. UNDERTAKER **J. C. Thomas** ADDRESS **3111 Locust**

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.

PERMANENT RECORD

PARENTS

