

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

Do not use this space.

18760

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No. *5628*)

Registration District No. *791*
Primary Registration District No. *1008*
(No. *5628* *Conright (Mar.)*)

File No.
Registered No. *5155*
St. Ward)

2. FULL NAME

(a) Residence. No. *5628 Conright* St. *5* 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. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *Negro* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *2-27-1845*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min.
83 | *2* | *11*

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *Piqua Ohio*
(STATE OR COUNTRY)

10. NAME OF FATHER *Robert Smith*

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

12. MAIDEN NAME OF MOTHER *Melina Jackson*

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

14. INFORMANT *Grace James*
(Address) *5628 Conright (Mar.)*

15. FILED *11* 19*28* *May C. Stebbins* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5-8-1928*

17. I HEREBY CERTIFY That I attended deceased from *May 1* 19*28*, to *May 8* 19*28* that I last saw him alive on *May 8* 19*28* and that death occurred, on the date stated above, at *12:55 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy of cerebral Hemorrhage
(duration) yrs. mos. da.
Arterio-sclerosis
(SECONDARY) (duration) yrs. mos. da.

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

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

20. WHAT TEST CONFIRMED DIAGNOSIS? *Clumpage*
(Signed) *W. C. McClure, M.D.*
5-10 19*28* (Address) *2325 Franklin*

*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 *Greenwood* DATE OF BURIAL *5-11-1928*

20. UNDERTAKER *States* ADDRESS *4407 9th Ferry*

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.

