

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

Do not use this space.

32191

1. PLACE OF DEATH

County St. Louis
Township St. Louis
City St. Louis (No. City Hosp. # 2)

Registration District No. 791
Priority Registration District No. 1003

File No. 9493
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 1423 Walnut St. Ward. 25
(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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5a. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mabel Ailef

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 4 1/2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labour
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mabel Ailef
(STATE OR COUNTRY) 2823 N. Tremont

14. INFORMANT (Address) Thomas C. Jones
Kansas City, Mo.

15. FILED SEP 25 1928 REGISTRAR W. U. Starkey

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 23rd 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date stated above, at _____, 7:10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Burns received while repairing Boilers in Burning Building

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

18. WHERE WAS DISEASE CONTRACTED
NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. W. Kerner
, 19____ (Address) Def. Coroner

*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 Kansas City, Mo. DATE OF BURIAL 9/20/28

20. UNDERTAKER R. E. Houston ADDRESS Thomas

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.

