

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

Do not use this space.

35462

1. PLACE OF DEATH

County..... Registration District No. **791**
 Townshp. **St. Louis No. 2** Primary Registration District No. **10034** File No.
 City **St. Louis** Hospital **Ward** Registered No. **10520** St. Ward)

2. FULL NAME

(a) Residence. No. **1017 N. 12th** St., **75** Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred **40** yrs. 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 **Col.** **Widowed**

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

Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Not known**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
about 65	5	-	-	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN): **Hannibal**
 (STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER **Not known**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Not known**
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Not known**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Not known**
 (STATE OR COUNTRY)

14. INFORMANT **Lillie Jones**
 (Address) **1017 N. 12th St.**

15. FILED **OCT 26 1928** **David Starkey**
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **19**

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.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Hypertension
935

CONTRIBUTORY (SECONDARY)

Ma
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH

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

7. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)..... M. D.

x . 158 (Address) **Conover**

*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 Cemetery** **DATE OF BURIAL** **10/26 1928**

20. UNDERTAKER **Heuser Bros. Jeff** **ADDRESS** **2152**

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.

