

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

Do not use this space.

**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. **35669**  
 Registered No. **10780**

**2. FULL NAME**

(a) Residence. No. 2720 Sheridan St., 7 Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 8 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 Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 29, 1903

7. AGE      YEARS      MONTHS      DAYS      If LESS than 1 day, hrs. or min.  
24      10      25

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

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

10. NAME OF FATHER Emmet Crawford  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Miss  
 12. MAIDEN NAME OF MOTHER Ellie Armstrong  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Miss

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

15. FILED Nov 3 1928 REGISTRAR Maple Starbuck

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-24-1928

17. I HEREBY CERTIFY, That I attended deceased from 10-20-1928, to 10-24-1928, that I last saw him alive on 10-24-1928, and that death occurred, on the date stated above, at 6:35 p. m.

THE CAUSE OF DEATH\* AS FOLLOWS:  
Pulmonary Tuberculosis  
23H  
 (duration) yrs. 5 mos. ds.  
 CONTRIBUTORY (SECONDARY) 31  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH? no DATE OF.....  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? Falk & Heron  
 (Signed) T. S. Cunningham, M. D.  
 (Address) 2945 Parkford

\*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 Father Rickson DATE OF BURIAL Nov 3 1928

20. UNDERTAKER Dement - son ADDRESS 2700 Wash

M. 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.

