

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

Do not use this space.

4190

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
 Township..... *St. Louis* City Registration District No..... Registered No. *814*  
 City..... *St. Louis* (No. *City Hospital # 2*) St. .... Ward)

**2. FULL NAME**

*Taylor Stevenson*  
 (a) Residence, No. *2814* *Howard* St., *20* Ward. (If nonresident, give city or town and State)  
 (Usual place of abode)

Length of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

|                       |                                 |   |
|-----------------------|---------------------------------|---|
| 3. SEX<br><i>Male</i> | 4. COLOR OR RACE<br><i>Col.</i> | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED<br><i>Widowed</i> |
|-----------------------|---------------------------------|---|

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

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

|             |           |        |      |  |
|-------------|-----------|--------|------|--|
| 7. AGE      | YEARS     | MONTHS | DAYS | IF LESS than 1 day, ..... hrs. or ..... min. |
| <i>abt.</i> | <i>52</i> |        |      |  |

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) (STATE OR COUNTRY) *La.*

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT (Address) *Mrs. J. Woodard City Hospital # 2*

15. FILED *7* 19 *1929* REGISTRAR *W. C. Starnes*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *1-13-1929*

17. I HEREBY CERTIFY, That I attended deceased from *1-12-1929* to *1-13-1929* that I last saw him alive on *1-13-1929*, and that death occurred, on the date stated above, at *11:15 P.* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Jabor Dysentery*  
*198*

(duration) yrs. mos. ds. *9*  
 CONTRIBUTORY (SECONDARY) *W/O*  
 (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  
 (Signed) *T. E. Birmingham*, M. D.  
 , 19 (Address) *2945 Shulton*

\*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 DATE OF BURIAL  
*Father Dickson* *1/18 1929*

20. UNDERTAKER ADDRESS  
*R. E. Houston* *Thomson St.*

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.

35  
2  
31  
31

