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

Do not use this space. (24) 4879 ~~24~~ 2

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 1651

City St Louis (No. Missouri Pacific Hospital St. ..... Ward)

2. FULL NAME Elijah Cheers

(a) Residence. No. 2323 Adams St., 22 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. 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	Colored	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt 1873

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt	55	Unknown		

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) Nashville
(STATE OR COUNTRY) Tenn

PARENTS

10. NAME OF FATHER Abram Cheers.

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

12. MAIDEN NAME OF MOTHER Kitty Breese

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

14. INFORMANT Mrs. Mattie Robinson
(Address) 2323 Adams St.

15. FILED ..... 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/31 1929

17. I HEREBY CERTIFY, That I attended deceased from 1/30/29 1/30, 1929, to 1/31, 1929, that I last saw him alive on 1/31, 1929, and that death occurred, on the date stated above, at 1.45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia lyt
104
93C
101A
(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Myocarditis Chronic
(duration) 9 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? no. DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination
(Signed) H B Dickinson, M. D
, 19 (Address) Mo. Pac Hospital

*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 Chicago, Ill. DATE OF BURIAL Feb 4 1929

20. UNDERTAKER W.C. Gordon Und. Co. ADDRESS 2649 Morgan St.

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.

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