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

Do not use this space.

8355

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. .....

Registered No. 2008

2. FULL NAME Rube White

(a) Residence. No. 3424 Walnut St., 18 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 25 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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF: Dora White

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec. 31, 1871

7. AGE: Years 57 | Months 1 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

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): Kansas

PARENTS

10. NAME OF FATHER: Wright White
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Kans.
12. MAIDEN NAME OF MOTHER: Annie Bias
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Kans.

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

15. FILED FEB 12 1929, 19.. Max C. Starkloff, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2-8- 1929

17. I HEREBY CERTIFY, That I attended deceased from 2-7-, 1929, to 2-8-, 1929, that I last saw him alive on 9-8-, 1929, and that death occurred, on the date stated above, at 4:50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. myocarditis
131
93C (duration) yrs. 10 mos. ds.

CONTRIBUTORY (SECONDARY): Chr. nephritis
(duration) yrs. mos. ds.

1290

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? Fair

(Signed) T. E. Cunningham, M.D.
, 19 (Address) 2945 Fairview

*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: Washington Park
DATE OF BURIAL: 2-14 1929

20. UNDERTAKER: W. Swade
ADDRESS: 4202 Finney ave

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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