

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

Do not use this space.

8637

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1093** File No.
 City **St. Louis** (No. **City Hospital #2**) Registered No. **2308** (Ward)

2. FULL NAME

(a) Residence. No. **3428 Laclede** St., **17** Ward. (If nonresident give city or town and State)
 (Usual place of abode)

Length of residence in city or town where death occurred **12** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **male** 4. COLOR OR RACE **Negro** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **single**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **February 2, 1929**

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

17. I HEREBY CERTIFY That I attended deceased from **January 30, 1929, to February 2, 1929**, that I last saw **him** alive on **February 2, 1929**, and that death occurred on the date stated above, at **9:20 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **3-15-1890**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
38 | **10** | **17** |

Acute primary leptemia
 (duration) **9 1/2 mos. 3 da.**

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

CONTRIBUTORY (SECONDARY) **Acute urinary Charazation**
Gangrene of Penis, Scrotum, and

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **Alabama**

11. WHERE WAS DISEASE CONTRACTED? **at home**
 IF NOT AT PLACE OF DEATH... **gonococcus**

10. NAME OF FATHER

Tom Fleming

DID AN OPERATION PRECEDE DEATH... DATE OF

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Miss**

8. WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Chylopathological**

12. MAIDEN NAME OF MOTHER

Eva Unknown

(Signed) **J. J. Proffers**, M. D.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Miss**

*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.

14. INFORMANT

(Address) **Anna F. Woodard**
City Hospital #2

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Proctor Dixon**

DATE OF BURIAL **2-19-1929**

15. FILED

20 1929
W. C. Stander
 REGISTRAR

20. UNDERTAKER **B. Leonard & Co.**

ADDRESS **2792 Lawton**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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