

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

Do not use this space.

9006

1. PLACE OF DEATH

County.....

Registration District No. **79**

100

Township.....

City **St. Louis**

Primary Registration District No. **City Hospital # 2**

File No.

Registered No. **2712**

St.

Ward)

2. FULL NAME

(a) Residence. No. **309** **Carroll** St., **23** Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **9** 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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

male

Col.

Single

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

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

Aug. 20 1895

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

33

6

4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Labourer

(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)

Ga.

10. NAME OF FATHER

Nathan Freeman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ga.

12. MAIDEN NAME OF MOTHER

Elmira Parks

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ga.

14. INFORMANT

(Address)

**Anna F. Woodard
City Hospital # 2**

15. FILED

19

May C. Storkoff
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2-24-1929**

17.

I HEREBY CERTIFY That I attended deceased from **2-24-1929** to **2-24-1929** that I last saw him alive on **2-24-1929**, and that death occurred, on the date stated above, at **6:10 P.M.**

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pulmonary Tuberculosis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

1. DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **F. E. Birmingham, M. D.**

, 19 (Address) **1945 Barlow**

*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

Brook Washington Ave.

3/3 1929

20. UNDERTAKER

ADDRESS

R. M. C. Green

3517 Laclede

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

