

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

Do not use this space.

16581
4688

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

File No.....
Registered No.....
St..... Ward)

2. FULL NAME

(a) Residence No. **1655 # 39** St. **17** Ward.....
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

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

male white Widowed

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

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

July 25 1865

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

63 9 28

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

Janitor

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ohio

10. NAME OF FATHER

John Clark

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ohio

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

INFORMANT

(Address)

Charles E. Starnes
City of St. Louis

15. FILED

APR 23 1929

Wm. C. Starnes

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 21 1929*

17. I HEREBY CERTIFY, That I attended deceased from *March 22 1929* to *April 21 1929* that I last saw him alive on *April 21 1929* and that death occurred, on the date stated above, at *7:08 p. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chronic Myocarditis
Chronic Nephritis
1.31*

CONTRIBUTORY (SECONDARY)

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) *Edward Melby, M.D.*

1929 (Address) *City of St. Louis*

*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

Bellefontaine

4/24 1929

20. UNDERTAKER

ADDRESS

Ch. Hoffmann & Co.

1711 Broadway

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.

236
2
2
31

Class.