

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

Do not use this space.

29120

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City.....

(No. City Hospital)

File No.....

Registered No. 8593

St. Ward)

2. FULL NAME

(a) Residence. No. 2812 N. Broadway, St. 26 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

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

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

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

Jan 22 - 1929

7. AGE

YEARS

MONTHS

DAYS

IF LESS than a day, hrs. or min.

5

30

8. OCCUPATION OF DECEASED

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

598

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

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)

St. Louis

(STATE OR COUNTRY)

10. NAME OF FATHER

Mose McCoy

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Massouri

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Ira Arnold

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Massouri

(STATE OR COUNTRY)

14. INFORMANT

(Address) City Hospital

15. FILED

Miss C. Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Aug 21 1929

17. I HEREBY CERTIFY That I attended deceased from Aug 11 1929 to Aug 21 1929 that I last saw him alive on Aug 21 1929 and that death occurred, on the date stated above, at 7:15 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Urticaria Medic (RtH)
Acute Nephritis
cause unknown (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS Clinical Laboratory

(Signed) Carl P. H. H. M. D.

8/21 1929 (Address) City 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

St. Matthews Cent.

DATE OF BURIAL

Aug 21 1929

20. UNDERTAKER

Burick & Dickens 1138 N. 6th

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

McCoy.