

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

Do not use this space.

35764

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **4234**)

Enright

File No.

Registered No. **10561**

St. Ward)

2. FULL NAME

(a) Residence, No. **4234** **Enright** St., **19** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **30** 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 **Colored** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **not known**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **not known**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
about 65	-	-	-	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. **Porter**
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Marshall**
(STATE OR COUNTRY) **Texas**

10. NAME OF FATHER **not known**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **unknown**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Amanda Clark**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Texas**
(STATE OR COUNTRY)

14. INFORMANT **Mrs. Jennie O. Gells**
(Address) **4234 Enright**

15. FILED **OCT 28 1929** **W. C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **10/25 1929**

17. I HEREBY CERTIFY, That I attended deceased from **May** 1928, to **Dec 25** 1929 that I last saw him alive on **Dec 25** 1929 and that death occurred, on the date stated above, at **5:15** p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
131
936 (duration) **1** yrs **5** mos. ds.

CONTRIBUTORY (SECONDARY) **Myocarditis Chronic**
(duration) **4** yrs. **4** mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT A PLACE OF DEATH:

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

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **W. C. Stanley** M. D.

10-26, 1929 (Address) **615 So. James**

*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

St. Peter's Cemetery **Oct. 28, 1929**

20. UNDERTAKER

ADDRESS **3100**

Peoples Und. Co. **Franklin**

WRITE PLAINLY, WITH INKING INK--THIS IS A PERMANENT RECORD

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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