

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

Do not use this space.

42932

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(No.....

ISOLATION HOSPITAL

File No.....

Registered No.....

12730

St.....

Ward)

**2. FULL NAME**

Anthony Grady

(a) Residence. No.....

2717

Lucas

St.,

21

Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

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)

Widower

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

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

Unknown

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ..... hrs. or ..... min.

63

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)

Odd jobs

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

14.

INFORMANT

e. Sheridan

(Address)

ISOLATION HOSPITAL

15.

FILED

19

LEG 311-1924

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

12-17 1929

17.

I HEREBY CERTIFY, That I attended deceased from

12-16

19

to

12-17

1929

that I last saw him alive on 12-17, 1929, and that death occurred, on the date stated above, at 12:55 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Myocarditis

CONTRIBUTORY (SECONDARY)

(duration) 3 yrs. mos. ds.

Bronchopneumonia

(duration) yrs. mos. 2 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?

(Signed)

B. K. Kibbel

M. D.

12-17 1929 (Address) ISOLATION 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

DATE OF BURIAL

Washington Ave

12-30 1929

20. UNDERTAKER

ADDRESS

Watson and Son 2769 Chouteau

WRITE PLAINLY, WITH UNFADING 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.

437  
39

