

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**
1003

Township.....

Primary Registration District No.

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

File No. **2774**
Registered No. **212**
St. Ward)

2. FULL NAME

(a) Residence. No. **3006 1/2 Park** St. **17** Ward.

Length of residence in city or town where death occurred **1 1/2** 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

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male**
4. COLOR OR RACE **White**
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 6 1930**

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF **Margaret Spalding**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 3 1930** to **Jan 6 1930** that I last saw him ~~live~~ **die** on **Jan 6 1930** and that death occurred, on the date stated above, at **12:30 a.m.**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 9, 1840**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
89 6 28

98B. Acute Haemorrhage of left foot 107
(duration) yrs. 1 mos. ds.

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

CONTRIBUTORY (SECONDARY) **1510**
(duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.

10. NAME OF FATHER **Unknown**

2 DID AN OPERATION PRECEDE DEATH? **No** DATE OF **1/4/30**

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

WAS THERE AN AUTOPSY? **No**

12. MAIDEN NAME OF MOTHER **Unknown**

WHAT TEST CONFIRMED DIAGNOSIS? **H. Berg**
(Signed) M. D.

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

1/6 30 (Address) **City Hospital**

14. INFORMANT **E. K. ...**
(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.

15. FILED **JAN -7 1930** REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **National Cemetery** DATE OF BURIAL **1/8 1930**

20. UNDERTAKER **City Hospital** ADDRESS **7814 S. 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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

1588
31

Spalding