

**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  
Township..... Primary Registration District No. 1003  
City St. Louis (No. 2215 Park Ave.)

3194 2789  
3360  
Registered No. 868  
St. \_\_\_\_\_ Ward)

**2. FULL NAME**

Charles Richard Stevenson

(a) Residence. No. 2215 Park St., 22 Ward.

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept-8-1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
53 4 15

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Carpenter 928  
(b) General nature of industry, business, or establishment in which employed (or employer) 1007  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Anawconda  
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Helson Stevenson

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

12. MAIDEN NAME OF MOTHER Phoebe Johnson

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

14. INFORMANT Emma Stevenson  
(Address) 2215 Park Ave.

15. FILED 27 1933 REGISTRAR W. C. Murphy

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 23 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1930 to Jan 23 1930 that I last saw him alive on Jan 23 1930 and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Bronchitis  
Non Tubercular  
(duration) 4 yrs. mos. ds.  
CONTRIBUTOR Metrial Regurgitation  
(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Mo.  
IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

19. WHAT TEST CONFIRMED DIAGNOSIS no  
(Signed) Dr. W. O. Lorschert, M. D.

(Address) 25 1930 2607 24 Franklin  
\*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 Sullivan Mo. DATE OF BURIAL 1-26-1930

20. UNDERTAKER Thos. P. Schaffer ADDRESS Sullivan Mo.

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.

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