

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

3578 use this space.

~~2104~~

~~2005~~

**1. PLACE OF DEATH**

County.....

Registration District No. *75077*

Township.....

Primary Registration District No. *2105*

City *St. Louis*

(No. *3600*)

*Arseval*

File No. ....

Registered No. *1082*

St. *24th*

(Ward)

**2. FULL NAME**

*Harold Charleston*

(a) Residence. No. *2215 Biddle*

St. *211*

Ward.

(Usual place of abode)

(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)

*single*

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

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

*Jan 3, 1930*

7. AGE

YEARS

MONTHS

DAYS

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

*27*

8. OCCUPATION OF DECEASED

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

*none*

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

*St. Louis mo*

(STATE OR COUNTRY)

10. NAME OF FATHER

*Alvin Charleston*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

*Alton, Ill*

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

*Matilda Comrie*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

*Galveston*

(STATE OR COUNTRY)

*Texas*

14.

INFORMANT

(Address)

*c. Sheridan*

*ISOLATION HOSPITAL*

15.

FILED

19

*Mar C. T. Miller*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

*1-30 1930*

17.

I HEREBY CERTIFY, That I attended deceased from

*1-29*, 19*30* to *1-30*, 19*30*

that I last saw him alive on *1-30*, 19*30* and that

death occurred, on the date stated above, at *7:15 P.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Erysipelas of face head & body (Cause Unknown)*

*150*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (SECONDARY)

*210*

(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?

(Signed)

*Alfred Hill*

M. D.

*1-30* 19 *30* (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 Park*

*211*

*1930*

20. UNDERTAKER

ADDRESS

*St. Louis Funeral Home*

*4107 Quincy*

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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