

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

Do not use this space.

7054

1. PLACE OF DEATH

County.....
Township.....
City St. Louis (No. 3600, Arsenal)

Registration District No. 791
Primary Registration District No. 1003

File No.....
Registered No. 1920
St. 24th Ward

2. FULL NAME

Ralph Prineau
(a) Residence. No. 4059 Lincoln St., 11 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6/6/15

7. AGE	YEARS	MONTHS	DAY	IT LESS than 1 day, hrs. or min.
	<u>14</u>	<u>8</u>	<u>17</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Iowa
(STATE OR COUNTRY)

10. NAME OF FATHER Peter E. Prineau

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

12. MAIDEN NAME OF MOTHER Iva J. Simone

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

14. INFORMANT Joe Rappier
(Address) ISOLATION HOSPITAL

15. FILED 31 19 19 May 17 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-23 19 30

17. I HEREBY CERTIFY, That I attended deceased from 1-22, 19 30, to 2-23, 19 30
that I last saw him alive on 2-22, 19 30 and that death occurred, on the date stated above, at 12:15 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis, meningococci

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DURATION yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) 24
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.

1-23, 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 Laurel Hill DATE OF BURIAL Feb 26 19 30

20. UNDERTAKER Walth Hermann & Son ADDRESS 2161 2nd Fair Ave

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.

WHITE COPY TO BE FILED WITH ORIGINAL RECORDS

