

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

Do not use this space.

11079

1. PLACE OF DEATH

County.....
Township.....
City St. Louis mo. (No. City Hospital #2)

Registration District No. 791
Primary Registration District No. 1003

File No.....
Registered No. 3113
St..... Ward.....

2. FULL NAME

(a) Residence. No. 716 N. Jefferson 21 Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 10 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>col.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>-</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>9-10-1876</u>		
7. AGE	YEARS <u>53</u>	MONTHS <u>6</u>
	DAYS <u>11</u>	IF LESS than 1 day,hrs. ormin.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>odd jobs</u> (c) Name of employer		

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

PARENTS	10. NAME OF FATHER <u>Robert Morris</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) <u>unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Maria White</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) <u>unknown</u>

14. INFORMANT (Address) A. Gertrude Creath City Hospital #2

15. FILED..... 19.....
REGISTRAR [Signature]

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-21-1930

17. I HEREBY CERTIFY, That I attended deceased from 3-17-1930 to 3-21-1930 that I last saw him alive on 3-21-1930, and that death occurred, on the date stated above, at 8:35 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
2 1/2 (duration) - yrs 8 mos. ds.
4-30
CONTRIBUTORY Pulmonary Tuberculosis
(SECONDARY) (duration) - yrs 4 mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF.....

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical & X-Ray
(Signed) A. C. Hale, M. D.
3/21/1930 (Address) City Hospital #2

*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 Father Pickson

20. UNDERTAKER Rememb - son

DATE OF BURIAL 3-28-1930
ADDRESS 2700 Wash

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.

