

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

Do not use this space.

14931

**1. PLACE OF DEATH**

County.....

Registration District No. 791

Township St. Louis, Mo.

Primary Registration District No. 1908

City St. Louis, Mo. (No. City Hospital)

File No. ....

Registered No. 4356.

St. .... Ward)

**2. FULL NAME**

Lemon Milton

(a) Residence. No. 4342 Garfield // Ward. ....

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 23 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

col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

—

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

5-19-1873

7. AGE

YEARS

MONTHS

DAYS

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

56

11

9

8. OCCUPATION OF DECEASED

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

Expressman

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ala.

10. NAME OF FATHER

Lynius Molton

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ala.

12. MAIDEN NAME OF MOTHER

Nancy Martin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

W. Va.

14. INFORMANT

(Address)

A. Bettrude Creach  
City Hospital #2

15. FILED

19

Wm. C. Stork  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

4-28-1930

17.

I HEREBY CERTIFY, That I attended deceased from 4-14-1930 to 4-28-1930 that I last saw him alive on 4-28-1930 and that death occurred, on the date stated above, at 9:30 AM

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic myocarditis  
93C

(duration) yrs. 6 mos. — ds.

CONTRIBUTOR (SECONDARY)

NOB

(duration) yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH NO DATE OF .....

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS

Clinical

(Signed) A. E. Hale, M. D.

4/29/1930 (Address) City Hosp. #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

DATE OF BURIAL

Greenwood Cem.

5/7/1930

20. UNDERTAKER

ADDRESS

J. M. Hughes

2629  
Lawton

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.

10  
5  
2

