

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

Do not use this space.

17758

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. **791**  
Primary Registration District No. **1003**  
City **St. Louis Mo. City Hospital #2**

File No. **4852**  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **23029 Carr** St., **21** Ward.  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **6** 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 **Single**  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **8-12-1900**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**29 8 26**

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. **Laborer on Ice**  
(b) General nature of industry, business, or establishment in which employed (or employer). **Truck**  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Miss**

PARENTS  
10. NAME OF FATHER **Steve Westbrooke**  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Miss**  
12. MAIDEN NAME OF MOTHER **Clara Westbrooke**  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Miss**

14. INFORMANT. **A. Strudelbreath**  
(Address) **City Hospital #2**

15. FILED **MAY 18 1930** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **5-8 1930**

17. I HEREBY CERTIFY, That I attended deceased from **5/4** 19**30** to **5/8** 19**30**  
that I last saw him alive on **5/8** 19**30** and that death occurred, on the date stated above, at **2 250** m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Lobar Pneumonia**  
**10 8** (duration) yrs. mos. **10** ds.  
CONTRIBUTORY (SECONDARY) **10/10** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Chinical**  
(Signed) **H. E. Hale** M. D.

**5/9** 19**30** (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 DATE OF BURIAL  
**Moorehead, Miss** **5/18 1930**

20. UNDERTAKER ADDRESS  
**D. S. Williams** **3232 Pine**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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