

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

Do not use this space.

18153

**1. PLACE OF DEATH**

County.....  
Township.....  
City *St. Louis* (No. ....)

Registration District No. *701*  
Primary Registration District No. *1003*

File No. ....  
Registered No. *5318*  
St. *24* Ward)

**ISOLATION HOSPITAL**

**2. FULL NAME**

(a) Residence. No. *216 Leffrances* Ward. *23*  
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *0* yrs. *3* mos. *7* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*Male* | *White* | *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 18, 1921*

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, ..... hrs. or ..... min.  
*8* | *10* | *12*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *nil* *820*  
(b) General nature of industry, business, or establishment in which employed (or employer) *159*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *J. Mo.*

10. NAME OF FATHER *John Odom*

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

12. MAIDEN NAME OF MOTHER *Goldie Noriega*

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

14. INFORMANT (Address) *Lorraine Kroner*  
**ISOLATION HOSPITAL**

15. FILED *MAY 31 1930* REGISTER *W. C. Stull*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 30 1930*

17. I HEREBY CERTIFY, That I attended deceased from *May 29*, 19*30*, to *May 30*, 19*30* that I last saw h. *unstable* on *May 30*, 19*30* and that death occurred, on the date stated above, at *6:45 P.* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Paralysis of limbs and tubercular following birth injury*

(duration) *8* yrs. *10* mos. *12* ds.

CONTRIBUTORY (SECONDARY) *Pneumonia following measles* (duration) yrs. mos. *4* ds.

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

19. DID AN OPERATION PRECEDE DEATH DATE OF

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *Alfred*, M. D.

**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 *St. Matthews* DATE OF BURIAL *May 31 1930*

20. UNDERTAKER *Wacker Heldele* ADDRESS *733 S. Blum*

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.

