

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

Do not use this space.

1. PLACE OF DEATH

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

Registration District No. 791
1003
Primary Registration District No.

File No. 28400
Registered No. 8280
St. (Ward)

2. FULL NAME

(a) Residence. No. 2873 Easton St. 21 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 16 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 Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-25-1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
38 7 20

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

10. NAME OF FATHER John Allen

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

12. MAIDEN NAME OF MOTHER Susie Watson

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

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

15. AUG 19 1930 Max C. Stark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-15-1930

17. I HEREBY CERTIFY, That I attended deceased from 8-13-1930, 1930, to 8-15-1930, 1930 that I last saw h.i.m. alive on 8-15-1930, and that death occurred, on the date stated above, at 5:55 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
100 (duration) yrs. mos. 3 ds.

CONTRIBUTORY Unkown (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Unkown

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy - Clinical - X-ray
(Signed) Henry C. Sturgeson, M. D.

8-16-1930 (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 DATE OF BURIAL

gufferson Baruch Aug 20 1930

20. UNDERTAKER Emmett Toney Co ADDRESS 36 Parson

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.

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