

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

Do not use this space.

28428

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis (No. ....)

File No. ....  
Registered No. 8310  
St. .... Ward)

**2. FULL NAME**

Westly Broomfield  
(a) Residence. No. 2731 Mill 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 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>Widowed</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov 26 - 1879</u>			
7. AGE	YEARS <u>50</u>	MONTHS <u>8</u>	DAYS <u>21</u>
	If LESS than 1 day, ..... hrs. or ..... min.		
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)..... (c) Name of employer.....			

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

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

14. INFORMANT Lula Gossy  
(Address) 2731 Mill st

15. FILED AUG 20 1934 19 May E. Starnes REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8 - 17 1930  
17. I HEREBY CERTIFY, That I attended deceased from 8 - 13 1930 to 8 - 17 1930 that I last saw him alive on aug 16 1930 and that death occurred, on the date stated above, at 10:40 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Apoplexy, Cerebral Hemorrhage  
(duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED? 7401  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

19. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physioid  
(Signed) Dr. Purdie M. D.  
, 19 (Address) 2746 9th

\*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 <u>Greenwood</u>	DATE OF BURIAL <u>8/23 1930</u>
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20. UNDERTAKER <u>Reinent - son</u>	ADDRESS <u>2700 Wash st</u>
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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. WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

