

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

Do not use this space.

12173

1. PLACE OF DEATH

County.....

Registration District No.....

791

100%B

Township.....

Primary Registration District No.....

City St. Louis (No. St. Paul Hospital)

File No.....

Registered No. 3434

St.....

Ward.....

2. FULL NAME

(a) Residence. No. 8855 Windom St., 6 Ward, St. Louis Co., Mo.

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

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

single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 28-1884

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

1

8

20

8. OCCUPATION OF DECEASED

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

none

(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)

St. Louis Co

mo 1

10. NAME OF FATHER

Jos Darwin

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Osceola

mo

12. MAIDEN NAME OF MOTHER

May Prost

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Perryville

mo

14.

INFORMANT (Address)

Jos Darwin
8855 Windom ave

15.

FILED

Wm C. Stork

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) mar 18 1931

17.

I HEREBY CERTIFY, That I attended deceased from 3-16, 1931, to 3-18, 1931, that I last saw him alive on 3-18, and that death occurred, on the date stated above, at 3:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis

108 (duration)..... yrs. mos. da.

108 (duration)..... yrs. mos. da.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8855 Windom

DID AN OPERATION PRECEDE DEATH.....

no DATE OF.....

WAS THERE AN AUTOPSY.....

no

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) Clarence G. Plummer, M.D.

, 19 (Address) 1927 N. Union

*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

Osceola

3/20 1931

20. UNDERTAKER

Thos J. Finare

ADDRESS

1519 S. Grand Blvd

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.

WITH UNFADING INK—THIS IS A PERMANENT RECORD

