WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

26943

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

Township ..... Primary Registration District No. ..... File No. .....

City ..... (No. ..... St. ..... Ward) Registered No. 8142

ATION HOSPITAL

2. FULL NAME Melvin Daniels

(a) Residence. No. 1621 Wash St., 25 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	Colored	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-13-1928

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	2	7	9	

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Clearance Daniels
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Nellie B Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Joe Laffler
(Address) ISOLATION HOSPITAL

15. FILED 21 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 22 1931

17. I HEREBY CERTIFY, That I attended deceased from 7-2-, 1931, to 7-22-, 1931 that I last saw him alive on 7-21-, 1931, and that death occurred, on the date stated above, at 1 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diphtheria of Nose Throat & Larynx
10 10 107A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Bronchopneumonia
Secondary (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Home
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Absent Cardiac Action
(Signed) John Eschenbrenner M.D.
, 19 (Address) 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 Washington Park
DATE OF BURIAL 7-24 1931

20. UNDERTAKER A. F. Walton
ADDRESS 2701 Stoddard