

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

Do not use this space.

33111
File No. _____
Registered No. 10007
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. 791
Township _____ Primary Registration District No. 10075
City St. Louis Mo (No. City Hospital 2)

2. FULL NAME

James Gaston
(a) Residence No. 2702 Franklin 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 10 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>Coe</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>6-19-1910</u>		
7. AGE	YEARS	MONTHS
	<u>21</u>	<u>3</u>
		14
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Auto</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Mechanic</u>		
(c) Name of employer		

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

PARENTS	10. NAME OF FATHER <u>Milton Gaston</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Miss</u>
	12. MAIDEN NAME OF MOTHER <u>Fannie Meador</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Miss</u>	

14. INFORMANT A. Hartshorn Creath
(Address) City Hospital 2

15. FILED SEP 26 1931 Herb C. Stander
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-23-1931
17. I HEREBY CERTIFY, That I attended deceased from 9-18 1931 to 9-23 1931 that I last saw h. live on 9-23 1931 and that death occurred, on the date stated above, at 9:15 pm m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
3312
35
Chronic Tuberculosis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY Tuberculosis Pleuritis
(SECONDARY) (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Unknown
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) E. M. Smith M. D.
9/24 1931 (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 St. Louis Ill DATE OF BURIAL Sept 26 1931

20. UNDERTAKER J. L. Marshall ADDRESS St. Louis Ill

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.

