

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.
 36174
 File No. _____
 Registered No. **10700**
 St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
 Township _____ Primary Registration District No. **1003**
 City **St. Louis, Mo.** (N. **City Hospital 2**)

2. FULL NAME

(a) Residence No. **1616 1/2 Franklin St.** **25** Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* **4. COLOR OR RACE** *Coe* **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (*Wife the word*) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *8-1-1885*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
	<i>46</i>	<i>2</i>	<i>5</i>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Laborer*

10. Date deceased last worked at this occupation (month and year) *Unknown*

11. Total time (years) spent in this occupation *Unknown*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Georgia*

13. NAME *Unknown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *A certificate death +*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Washington* **DATE** *10-15* 19*31*

19. UNDERTAKER (ADDRESS) *Walter Richters 3500 Rutan St*

20. FILED 19 *May 6 Starloff* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10-9* 19 *31*

22. I HEREBY CERTIFY, That I attended deceased from *7-13* 19 *30* to *10-9* 19 *31*

I last saw him alive on *10-9-1931* Death is said to have occurred on the date stated above, at *1145* a.m.

The principal cause of death and related causes of importance were as follows:

124B
Chronic Myocarditis
Coronary atherosclerosis
54 yrs
 Other contributory causes of importance: *124B*
Chronic Myocarditis *34 yrs*

Name of operation _____ **Date of** _____
What test confirmed diagnosis? *Autopsy* **Was there an autopsy?** *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ **Date of injury** _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify *C.M. Smith*
 (Signed) _____ (Address) *City Hospital 2*, M. D.

