

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
1003
Primary Registration District No. *Josephine Hospital*

File No. **18623**
Registered No. **5116**
St. Ward)

2. FULL NAME

(a) Residence, No. *3911 Lafayette Ave* St., *17* Ward.

(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 MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 20* 19*34*

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

22. I HEREBY CERTIFY, That I attended deceased from *April 5* 19*34*, to *May 20* 19*34*

Last saw him alive on *May 19* 19*34*. Death is said to have occurred on the date stated above, at *2:30* a.m.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 16-1915*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 *8* *4*

Septicemia
Septicemia
Date of onset

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Mitchell-Mann Co*

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

Other contributory causes of importance:
Follicular tonsillitis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Solomons Mo*

13. NAME *William A. Morris*

Name of operation..... Date of.....

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

What test confirmed diagnosis?..... Was there an autopsy?.....

15. MAIDEN NAME *Mary Christy*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

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

Where did injury occur?..... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT *Mrs Mary Morris*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Calvary Cemetery* DATE *May 22 1934*

Manner of injury..... Nature of injury.....

19. UNDERTAKER *Peter Brand*

24. Was disease or injury in any way related to occupation of deceased? *No*

20. FILED *21 11* 19*34*

If so, specify *Dr. Williamson*, M. D.

(Signed) *J. Bredeck* Registrar. (Address) *3902 Lafayette*

JUN 19 1934

CAUSE OF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Dr Williamson
3902 Lafayette Ave

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 1003

File No.....
Registered No. 5116
St..... Ward.....

2. FULL NAME

(a) Residence, No..... St..... Ward.....
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 8 4

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.

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

11. Total time (years) spent in this occupation

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

MOTHER / FATHER 13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 9-1-34

SUPPLEMENTARY

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 20, 1934

22. I HEREBY CERTIFY, That I attended deceased from to 19.....
I last saw h..... alive on....., 19..... Death is said to have occurred on the m.

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

Peptococcus
in the foreign body but in my opinion it had come from the stomach
Contributory causes of importance:
all cellular contents

Name of operation..... Date of.....
What test confirmed diagnosis? 15a Was there an autopsy?

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.....
(Signed) O. E. Williamson M. D.
(Address) 390 2 Lafayette

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-18623