

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**
1003

File No. **26510**

Township.....

Primary Registration District No. **5400 Arsenal**

Registered No. **6678** Ward

City **St. Louis** (No. **City**)

City **Sanitarians**

St. **6678** Ward

2. FULL NAME

(a) Residence, No. **5039** **Cote Brillant** St., **6** Ward.

Length of residence in city or town where death occurred **35** yrs. **2** mos. **ds.** How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **white** 4. COLOR OR RACE **Walt** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb. 16, 1869**

7. AGE YEARS **65** MONTHS **4** DAYS **20** If LESS than 1 day, hrs. or min.

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

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

10. Date deceased last worked at this occupation (month and year) **June 1930** 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Scotland**

13. NAME **Unknown**

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

15. MAIDEN NAME **Unknown**

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

17. INFORMANT **Dr. Mullins M. D.** (ADDRESS) **5400 Arsenal**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Peters Cem.** DATE **July 7, 1934**

19. UNDERTAKER **Alexander Ed. Soff** (ADDRESS) **617 S. Delmar**

20. FILED **11-6 1934** 19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7-4, 1934**

22. I HEREBY CERTIFY, That I attended deceased from **12-7, 1931**, to **7-4, 1934**

I last saw him alive on **7-4, 1934** Death is said

to have occurred on the date stated above, at **11:30 a.m.**

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

93C
87D **93C**
Chronic Myocarditis **12-7-31**
Huntington Chorea & ptyphoid **12-7-31**

Other contributory causes of importance:

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

What test confirmed diagnosis **Clinical** 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) **Dr. Mullins** , M. D.
5400 Arsenal (Address)

THE UNIVERSITY OF CHICAGO
LIBRARY

1950

1950

1950

1950

1950

1950

1950

#2

St Louis

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

6678

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *John Mead*
Who died at _____ on *7-4-34*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex *W* Color or race *M* Single, married, widowed or divorced: _____

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: _____

Other contributory causes of importance _____

Name of operation _____ Date of _____

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

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 _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

(Signature of Registrar *J. J. Brebeck* *8-29-34*)

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. *791*

Primary Reg. Dist. No. *1003*

E. T. McGaugh M.D.

Special Agent.

26510