MARGIN RESERVED FOR BINDING

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 30521

or

Village ..... Primary Registration District No. 1003 Registered No. 8381

or

City St Louis (NO. City Hospital St. 6 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME 6727 Christ Scharfer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: April (Month) 3 (Day), 1844 (Year)

7 AGE: 74 yrs. 5 mos. ..... ds. If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Peddler
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country): Germany

PARENTS

10 NAME OF FATHER: Jules Scharfer

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Robine

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E Rowan

(Address) City Hospital

15 Filed SEP -5 1913, 191 Max C Starkloff Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 3 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 30, 1918, to Sept 3, 1918, that I last saw him alive on Sept 3, 1918, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Arterial Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Emil C Hein M. D.

Sept 3, 1918 (Address) City Hospital

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. 4 ds. In the State 38 yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence 30 Clark

19 PLACE OF BURIAL OR REMOVAL: St. Louis U

DATE OF BURIAL: Sep. 5, 1918

20 UNDERTAKER: Ziegler Bros

ADDRESS: 1426 Grattoni St

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

**1 PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

**6 DATE OF BIRTH**

..... 1..... (Month) (Day) (Year)

**7 AGE** .....yrs.....mos.....ds. | If LESS than 1 day,.....hrs. or.....min.?

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

**9 BIRTHPLACE** (City or town, State or foreign country)

**PARENTS**

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) .....

(Address) .....

**15**

Filed ....., 191....., .....
Registrar

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH**

..... (Month) (Day) 191..... (Year)

**17** I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....
that I last saw h.....alive on ....., 191.....,
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

**18 LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191..... |
|---|---|
| 20 UNDERTAKER | ADDRESS |

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.

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