LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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 ..... or Village ..... or City St Louis Mo (NO. City Hospital St.; 8 Ward)

Registration District No. 791 File No. 30335

Primary Registration District No. 1003 Registered No. 9709

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

2 FULL NAME John Martin (Mountain) 8217

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH Not Known (Month) (Day) (Year)

7 AGE abt. 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Lab. 34
(b) General nature of industry business, or establishment in which employed (or employer) 11A 167A

9 BIRTHPLACE (City or town, State or foreign country) Miss.

PARENTS
10 NAME OF FATHER Not Known
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) Hospital Information Otto R. Fritsch
(Address) City Hospital

15 Filed OCT 17 1913, 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 13 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 6, 1918, to Oct 13, 1918, that I last saw him alive on Oct 13, 1918, and that death occurred, on the date stated above, at 9:40 a.m.

The CAUSE OF DEATH* was as follows:
Influenza } autopsy
Syphilis } 10
(Duration) ..... yrs. ..... mos. ..... ds.

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

(Signed) Emil C. Hein M. D.
Oct 13, 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. 7 ds. In the State 22 yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence 1545 S. 2nd

19 PLACE OF BURIAL OR REMOVAL Greenwood

DATE OF BURIAL Oct 17, 1918

20 UNDERTAKER W. C. Gordon

ADDRESS 2649 Morgan

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

..... (Month) ....., 1..... (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) ....., 191..... (Day) (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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