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 St. Louis

Township Bonhomme — Registration District No. 785 — File No. 25882

or

Village — Primary Registration District No. 6031 — Registered No. 100

or

City (NO. , St.; Ward)

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

2 FULL NAME John Gabrisch

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: M

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Dec 15 (Month) (Day), 1850 (Year)

7 AGE: 68 yrs. 8 mos. 11 ds. — If LESS than 1 day, hrs. or min.?

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

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

PARENTS

10 NAME OF FATHER: Joseph Gabrisch

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

12 MAIDEN NAME OF MOTHER: Mary Kokot

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lizzie Gabrisch

(Address) Manchester Mo

15 Filed 8/28, 1919 Summerau Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: Aug (Month) 26 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 20, 1919, to Aug 26, 1919, that I last saw him alive on Aug 25, 1919, and that death occurred, on the date stated above, at 5.40 A.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Emfyema

(Duration) yrs. 1 mos. ds.

(Signed) Frank Sandfos M. D.

Aug 26, 1919 (Address) Ballwin Mo

*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: St. Josephs Cath. Cemetery — DATE OF BURIAL: Aug 28, 1919

20 UNDERTAKER: Wm. Schrader — ADDRESS: Ballwin Mo.

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) ..... (Day), 1..... (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.