

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

2992

**1. PLACE OF DEATH**

County..... Registration District No. *831* File No. ....  
 Township..... Primary Registration District No. *100002* Registered No. *669*  
 City *St. Louis* (No. *5190-9* *Easton Ave*, St. .... Ward)

**2. FULL NAME**

(a) Residence. No. *5190-9* *Easton Ave*, St. .... Ward. ....  
 (Usual place of abode) (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. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Elizabeth Mitchell*  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept. 26 - 1859*  
 7. AGE YEARS MONTHS DAYS IF LESS than 1/2 day, .... hrs. or .... min.  
*63 3 22*  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work *Glass Blower*  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*  
 10. NAME OF FATHER *Unknown*  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*  
 12. MAIDEN NAME OF MOTHER *Unknown*  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

14. INFORMANT *Elizabeth Mitchell*  
 (Address) *5190-9 Easton, Ave*

15. FILED *Mar 6 Starkoff*  
 REGISTER

**1 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 17<sup>th</sup> 1923*  
 17. I HEREBY CERTIFY, That I attended deceased from *Jan 17, 1923* to *Jan 17, 1923*.  
 (that I last saw him..... alive on..... *Jan 17, 1923*, and that death occurred, on the date stated above, at..... *10:40 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Angina pectoris*  
*94A*  
 (duration) yrs. mos. *9 mos.*

CONTRIBUTORY (SECONDARY).....  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED.....  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH? *No.* DATE OF.....  
 WAS THERE AN AUTOPSY? *No.*  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) *Wm. L. Pauley*, M. D.  
*Jan 16, 1923 (Address) 530, Easton Ave*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Walhalla Cemetery* DATE OF BURIAL *Jan 20<sup>th</sup> 1923*  
 20. UNDERTAKER *Geo. L. Plitisch, 5966 Easton Ave* ADDRESS

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.

