

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

21862

1. PLACE OF DEATH *St. Louis*  
 County..... **CARONDELLET** Registration District No. **1123** File No. ....  
 Township..... **CARONDELLET** Primary Registration District No. **6248** Registered No. **235**  
 City..... **MOUNT ST. ROSE SANATORIUM** (No. ....) St. .... Ward .....

2. FULL NAME *Patrick Fox*  
 (a) Residence. No. .... St. .... Ward. *Wood River 1st.*  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred **0** yrs. **0** mos. **2** 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 *Single* (write the word)  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *None*  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 10 - 1908*  
 7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. or min.  
*16*  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work *Student*  
 (b) General nature of industry, business, or establishment in which employed (or employer).....  
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Missouri*  
 (STATE OR COUNTRY)  
 10. NAME OF FATHER *Peter Fox*  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Mo.*  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER *Catherine O'Rourke*  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Mo.*  
 (STATE OR COUNTRY)

14. INFORMANT *Hopfer Ruman*  
 (Address) **MOUNT ST. ROSE SANATORIUM**  
 15. *7/13* 19 *25* *L. C. Obrock*  
 FILED REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 13 1925*  
 17. I HEREBY CERTIFY That I attended deceased from *July 12 1925* to *July 12 1925* that I last saw him alive on *July 13 1925* and that death occurred, on the date stated above, at *8:35 A.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*234*  
**CHRONIC PULMONARY TUBERCULOSIS**  
 (duration) *I do not know* yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) *None*  
 (duration) *—* yrs. *—* mos. *—* ds.

18. WHERE WAS DISEASE CONTRACTED *Not Known*  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH? *no* DATE OF .....  
 WAS THERE AN AUTOPSY? *no*  
 WHAT TEST CONFIRMED DIAGNOSIS? *None*  
 (Signed) *Jacovice Schlenker* M. D. *7/13 1925* (Address) *3511 S. Grand St. St. Louis*

\*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 *Louisiana Mo.* DATE OF BURIAL *July 15 1925*  
 20. UNDERTAKER *Clunk and Co* ADDRESS *Attyol.*

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.

