

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

AUG 26 1923

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

23029

1. PLACE OF DEATH

County *St. Louis*

Registration District No. *4*

File No. *3*

Township *St. Henry*

Primary Registration District No. *5759 B*

Registered No. *78*

City *St. Louis*

(No. *1*)

St.

Ward

2. FULL NAME

Henry Bax

(a) Residence No. *1*

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.

Da.

How long in U.S., if of foreign birth?

Yrs.

Mos.

Da.

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

Johanna Johns

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Not known

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, *hrs.*
or *min.*

55

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St. Thomas

(STATE OR COUNTRY)

Col. Ca. Iran

10. NAME OF FATHER

Joseph Bax

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Sophia Breien

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Bohemia

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

Herman Dornhoff
St. Elizabeth, Mo.

15.

FILED

July 5, 1923
John E. Schmeiderman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

July 4 1926

17.

I HEREBY CERTIFY That I attended deceased from *July 4 1926* to *July 4 1926*
and I last saw him alive on *July 4 1926* and that death occurred, on the date stated above, at *St. Elizabeth, Mo.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy - no medical attendance

CONTRIBUTORY

(SECONDARY)

Excessive Heat (duration) *19* yrs. *10* mos. *14* da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH

20. WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *E. W. Curtman, M.D.*

July 5, 1926 (Address) *St. Elizabeth, Mo.*

*State the DISEASE CAUSING DEATH, or in death 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

DATE OF BURIAL

St. Louis Cemetery
St. Elizabeth, Mo. *July 5 1926*

20. UNDERTAKER

ADDRESS

St. Schell & Sons Inc.
St. Elizabeth, Mo.

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.

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..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.....) St..... Sl..... Ward.....

2. FULL NAME

(a) Residence, No....., Ward.....
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If less than 1 day, hrs. min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw him..... alive on....., 19....., and that death occurred, on the date stated above, at.....
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed).....

, 19 (Address)

M. D

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