

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

Do not use this space.

2622

**1. PLACE OF DEATH**

County..... Registration District No.....  
Township..... Primary Registration District No.....  
City St. Louis (No. City of St. Louis) St. .... Ward.....

File No.....  
Registered No. 182  
St. .... Ward.....

**2. FULL NAME**

(a) Residence. No. 822 776 St., 25 Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1927

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

17. I HEREBY CERTIFY That I witnessed deceased from Jan 27 1927 to Jan 5 1927 that I last saw him live on Jan 5 1927 and that death occurred, on the date stated above, at 7:25 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 1 - 1879

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.  
47 | 4 | 4 | |

Lobar Pneumonia  
10 (duration) yrs. mos. da.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Upholsterer  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

CONTRIBUTORY (SECONDARY) 101d  
(duration) yrs. mos. da.

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Missouri

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

**10. NAME OF FATHER**

Philip Andersen

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Germany

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) Reuben M. Smith, M. D.

**12. MAIDEN NAME OF MOTHER**

Mary Misch

1/5, 1927 (Address) City of St. Louis

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Germany

\*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.

**14.**

INFORMANT (Address) Osman City Hospital

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Gion DATE OF BURIAL Jan 7 1927

**15.**

FILED 11-6 1927 Mar 6 Starloff

20. UNDERTAKER Wm Paschdag ADDRESS 2825 710 Grand All

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.

Smiderov.