

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

Do not use this space.

2831

1. PLACE OF DEATH

County.....

Registration District No.....

File No.....

Township.....

Primary Registration District No.....

Registered No. **408**

City **St. Louis Mo.** (No. **St. Johns Hospital 307 S. Euclid**) Ward

2. FULL NAME

(a) Residence No. **2763 Park av. 22** Ward.

(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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

male white widower

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

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

Aug. 2-1862

7. AGE

YEARS

MONTHS

Days

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

64 5 8

8. OCCUPATION OF DECEASED

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

Retired Baker

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

11 509 1001 748

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

10. NAME OF FATHER

Christ Handmann

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Winfredson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14.

INFORMANT (Address)

Miss Olga Handmann 2763 Park av.

15.

FILED

12 1927 Max S. Starckoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-10-27 19

17. I HEREBY CERTIFY, That I attended deceased from 1-5-27 to 1-10-27 death that I last saw him alive on 1/9/27, and that death occurred, on the date stated above, at 8:50 AM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Angina Pectoris

57 (duration) yrs. mos. 7 ds. CONTRIBUTORY Ch. Myocarditis, Ch. Parenchymatous (SECONDARY) Nephros. Diabetes Mellitus, (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X-ray

(Signed) **Hubert J. Staub**, M. D.

, 19 (Address) **2715 Park**

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

S.S. Peter & Paul's Cem. Jan 12 1927

20. UNDERTAKER

ADDRESS

E. J. Schuur 3125 Lafayette Ave

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.

