

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

Do not use this space.

3020

1. PLACE OF DEATH

County.....

Registration District No.....

791

File No.....

Township.....

Primary Registration District No.....

1023

Registered No.....

611

City *St. Louis Mo.* (No. *2224 Hickory St.*)

St. Ward)

2. FULL NAME

(a) Residence No. *2224 Hickory St. 22* 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

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. or 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)

PARENTS

14.

INFORMANT
(Address)

15.

FILED

18 1927

Max G. Starkoff

Registrar

MEDICAL CERTIFICATE OF DEATH

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

Jan 16, 1927

17.

I HEREBY CERTIFY, That I attended deceased from *Nov 3, 1924*, to *Jan 16, 1927*.
that I last saw h. or alive on *Jan 10, 1927*, and that death occurred, on the date stated above, at *4:30 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

13 Epilepsy cerebral Hemorrhage

CONTRIBUTORY (SECONDARY)

Chronic Interstitial Nephritis

18. WHERE WAS DEATH 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) *St. Louis Schaubert* M. D.

Jan 7, 1927 (Address) *2200 Chouteau av*

*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

SS. Peter + Paul's Cemetery Jan 19 1927

20. UNDERTAKER

E. J. Schuer 3125 Lafayette av.

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.

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