

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

Do not use this space.

3453

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **2604**, **Indiana**)

File No.

Registered No. **1089**

St. Ward)

2. FULL NAME

William Mares

(a) Residence, No. **2604 Indiana St.**, **23** 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) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **about 1878**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **alt. 49**

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Shoe Worker**

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis Mo** (STATE OR COUNTRY)

10. NAME OF FATHER **Joseph Mares**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Europe** (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Theresa Alt**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Europe** (STATE OR COUNTRY)

14. INFORMANT **Thekla Brown** (Address) **2604 Indiana**

15. FILED **Jan 31 1927** **Max B. Starckoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 29 1927**

17. I HEREBY CERTIFY That attended deceased from **Dec 30 1926** to **Jan 29 1927** that I last saw him alive on **Jan 29 1927** and that death occurred, on the date stated above, at **6 45 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
9:30 1103 Chronic Myocarditis.

CONTRIBUTORY **Pleurisy with Effusion (Left)** (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **Clinical Findings.**

(Signed) **B. W. Lippel** M. D.

, 19 (Address) **3772 56th Broadway**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURES OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

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

St Peter & Paul Jan 31 1927

20. UNDERTAKER **W. B. Moy dell** ADDRESS **1926 Allen**

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.

