APR 27 1927

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

Do not use this space.

9569

1. PLACE OF DEATH
County: St Louis — Registration District No. 1160 — File No. 625
Township: Central — Primary Registration District No. 4470 — Registered No.
City: University City (No. 727, Syracuse St., Ward)

2. FULL NAME: Charles Becker
(a) Residence. No. 727 Syracuse 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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: Lena Becker

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct. 13 - 1850

7. AGE: Years 76 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Furniture Dealer
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY): Germany

PARENTS
10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY): //

14. INFORMANT: Lena Becker
(Address): 727 Syracuse

15. FILED March 8, 1927 — Leo Bilz Deal M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 7 1927

17. I HEREBY CERTIFY, That I attended deceased from February 20, 1927, to March 7, 1927, that I last saw him alive on March 7, 1927, and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Aneurysm - Descending Aortic - Thoracic
(duration) — yrs. — mos. — ds.
CONTRIBUTORY (SECONDARY): Arterio - Sclerosis
(duration) — yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? X Ray
(Signed) Frank Hinchey, M. D.
, 19 (Address) Humboldt Bldg

*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: Mt. Sinai Cem. — DATE OF BURIAL: March 9 1927
20. UNDERTAKER: H. Rindskopf — ADDRESS: 6202 Delmar

PERMANENT RECO
FADING INK
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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1. PLACE OF DEATH

County St Louis — Registration District No. 1160 — File No. 5

Township Central — Primary Registration District No. 4470 — Registered No. .....

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Charles Becker

(a) Residence. No. ..... 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. ..... 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)
M	W	M

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)

PARENTS

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) Unknown
(STATE OR COUNTRY) Germany

14. INFORMANT .....
(Address)

15. FILED 5-12 1927 Lillian Bruns
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 7 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

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) ....., M. D

, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SHALL NOT RECEIVE A FEE ... CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIB...

...ry item of information should ... supplied. AGE ... EXACTLY. PHYSICIAN ... FOR OF DEATH in plain terms, so that it ... properly classified ... statement of OCCUPATION ...

S-9569