

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

Do not use this space.

13552

791

1003

File No.

Registered No. **3887**

1. PLACE OF DEATH

County..... Registration District No.....
 Township..... Primary Registration District No.....
 City..... (No. *Alexan Bros.*) St. Ward)

2. FULL NAME *Edward J. Levine*

(a) Residence. No. *Alex Bros. Hospital, 24* 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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt 70

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Retired 4 yr*
 (b) General nature of industry, business, or establishment in which employed (or employer) *City Fireman*
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ohio*

10. NAME OF FATHER *Edw. Levine*

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

12. MAIDEN NAME OF MOTHER *Bridget Levine*

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

14. INFORMANT *John Levine*
 (Address) *3500 Meramec St*

15. APR 23 1927 FILED *Max G. Starkeff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr 22 - 1927*

17. I HEREBY CERTIFY, That I attended deceased from *1/2*, 19*26* to *4/22*, 19*27* that I last saw *h.s.* alive on *4/22*, 19*27*, and that death occurred, on the date stated above, at *8:30 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Catarrhal Proctitis

97 (duration) yrs. mos. da. *11 80*
 CONTRIBUTORY *Arterio-Sclerosis* (SECONDARY) (duration) *1* yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *AB*
 IF NOT AT PLACE OF BIRTH.....

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....
 WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *H.H. Steinmann*, M. D. (Address) *5715 Southwest*

*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 *Calvary* DATE OF BURIAL *4-25 1927*

20. UNDERTAKER *Loether* ADDRESS *7315 J. Boody*

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.

