

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

Do not use this space.

16439

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

(No. **2122**, **8th** St.)

File No.

Registered No. **4329**

St.

Ward)

2. FULL NAME

(a) Residence, No. **2122**, **8th** 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.

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

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

Sept 4 - 1872

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

54

8

2

8. OCCUPATION OF DECEASED

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

Day Laborer

(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)

Germany

10. NAME OF FATHER

Henry Sadler

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

14.

INFORMANT

(Address)

*Amanda Sadler
2122 8th St*

15.

FILED

MAY - 8 1927

May 6 State of

REGISTERED

MEDICAL CERTIFICATE OF DEATH

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

May 6 1927

17.

I HEREBY CERTIFY, That I attended deceased from *May 2* 1927, to *May 6* 1927,

that I last saw him alive on *May 6* 1927, and that death occurred, on the date stated above, at *8:30 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Croupous (Lobar) Pneumonia

108

CONTRIBUTORY (SECONDARY)

1010

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).....

Carl Kew, M. D.

57, 1927 (Address) *1807 S 18*

*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

St. Matthews

May 9 1927

20. UNDERTAKER

Wacker Helderle

ADDRESS

2331 S Bldg

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.

