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

Do not use this space. 16467

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis Mo (No. ..... St. ..... Ward)

File No. ..... Registered No. 4358

2. FULL NAME John Heyde

(a) Residence. No. 820 Lafayette Ave 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 Eva Heyde

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feby 2-1885

7. AGE Years 42 Months 3 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

PARENTS

10. NAME OF FATHER Sebastian Heyde

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

12. MAIDEN NAME OF MOTHER Eva Hughiner

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

14. INFORMANT Eva Heyde (Address) 820 Lafayette Ave

15. FILED ..... 1927 Max C Starkeoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from April 24th, 1927, to May 7th, 1927, that I last saw him alive on May 7th, 1927, and that death occurred, on the date stated above, at 9 45 P M

THE CAUSE OF DEATH* WAS AS FOLLOWS:

107A Broncho pneumonia

106A

100A (duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (SECONDARY) Bronchitis acute

Non Tubercular (duration) — yrs. — mos. 14 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? At place of death

DID AN OPERATION PRECEDE DEATH? No DATE OF —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms

(Signed) W A Fries, M. D

5/9, 1927 (Address) 1544 So. Broadway

*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 St Peter and Paul

DATE OF BURIAL May 10 1927

20. UNDERTAKER Frieden U. C.

ADDRESS 1718 Lo[illegible]

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.