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

Do not use this space.

16596

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 4493

City St Louis (No. Bethesda Hospital St. ..... Ward)

2. FULL NAME Stephan B Thano

(a) Residence. No. 2642a Russell 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	white	Baby

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 25 - 1926

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
		7	17	

8. OCCUPATION OF DECEASED

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

(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) St Louis

PARENTS

10. NAME OF FATHER Bani J. Thano

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

12. MAIDEN NAME OF MOTHER Costindina Lucheny

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

14. INFORMANT Bani J. Thano
(Address) 2642a Russell

15. FILED MAY 13 1927, 19..... Max C Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 12 1927

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1927, to May 12, 1927, that I last saw him alive on May 12, 1927, and that death occurred, on the date stated above, at 3 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

24A Tuberculous Meningitis

32a (duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (SECONDARY) Tuberculosis of the Meninges (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) John Zahnsky, M. D

May 13, 1927 (Address) 536 N. Taylor

*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 Mathews Cem.	May 13 1927

20. UNDERTAKER	ADDRESS
Fred M Williams	4461 Delmar

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.

...IS A PERMANENT RECORD

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

1. PLACE OF DEATH

(Name) ..... (No. and street) .....

Township ..... Incorporated place .....

(County) ..... (No. ..... St. ..... Ward)

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

PERSONAL AND STATISTICAL PARTICULARS

2. FULL NAME .....

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. (Usual place of abode) ..... St. .....

3. SEX ..... 4. RACE OR COLOR ..... 5. WHITE OR NEGRO (Yes or No) ..... 6. DATE OF BIRTH (Month, day and year) .....

7. AGE ..... Years ..... Months ..... Days ..... If less than 1 day, ... hrs. ..... 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) .....

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) ..... (State or country) .....

14. INFORMANT ..... Address .....

15. ..... Date ..... 19 .....

16. Place of burial, cremation, removal ..... Date ..... 19 .....

17. UNDERTAKER .....

18. PLACE OF MORTUARY CHECK FOR MOTTUARY ..... Address .....

19. DATE OF DEATH (Month, day and year) ..... I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19 ..... and last saw ..... alive on ..... 19 ..... death occurred, as the date stated above, at .....

The cause of death was as follows:

.....

.....

.....

.....

20. Where did death occur? (Specify whether in hospital, institution, residence, factory, office, hotel, street, railroad car, or other place) .....

21. Was there an autopsy? .....

What test confirmed diagnosis? .....

Was operation performed? ..... Date of ..... 19 .....

Did an operation precede death? .....

If not at place of death? .....

22. Where was injury received? (Specify whether in industry, home, or public place) .....

23. Was injury due to negligence of another? .....

24. Was injury due to accident, suicide, or homicide? .....

25. Was injury during war? .....

26. Was injury during performance of duty? .....

27. Place of injury (Specify whether on farm, in factory, office building, street, railroad, or other place) .....

28. Time of injury ..... 19 ..... (Hour) .....

29. I hereby certify that I attended the deceased since ..... 19 ..... and last saw ..... alive on ..... 19 ..... The injury or illness stated above was the cause of death, and death occurred at ..... (Signed) .....

M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state