

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

Do not use this space.

17038

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City St Louis (No. 1614 S 12 St)

File No.....

Registered No. 4-5001

St.....Ward)

**2. FULL NAME**

(a) Residence. No. 1614 S 12 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)**

Single

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

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

Nov 21-1925

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, ..... hrs. or ..... min.

1

6

4

**8. OCCUPATION OF DECEASED**

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

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

St Louis Mo

**10. NAME OF FATHER**

John Uchotrichy

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Europe

**12. MAIDEN NAME OF MOTHER**

Mildred Mana

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Europe

**14.**

INFORMANT

(Address)

John Uchotrichy  
1614 S 12 St

**15.**

FILED

23

1927

Man, 6 St. Louis

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

May 27 1927

**17.**

I HEREBY CERTIFY, That I attended deceased from May 27, 1927, to May 27, 1927, and that I last saw him alive on May 27, 1927, and that death occurred, on the date stated above, at.....5 P.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Whooping Cough  
9 (duration) yrs. mos. ds.  
107A

**CONTRIBUTORY (SECONDARY)**

Broncho pneumonia  
Secondary (months) yrs. mos. 3 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)

Robert G. Hauke M. D.  
May 28, 1927 (Address) 1823 Menard St.

\*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

New Orleans

May 28 1927

**20. UNDERTAKER**

ADDRESS

H. S. Moy dell

1926 Allen

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.

PROPERTY OF THE MISSOURI STATE BOARD OF HEALTH—THIS IS A PERMANENT RECORD

OK  
Person