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

Do not use this space.

20100

File No. 5867

Registered No.

1. PLACE OF DEATH

County

Township

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

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME 3794 Peter Becker

(a) Residence. No. 519a Walnut St., 25 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 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): Unknown

7. AGE: abt. 55 YEARS | MONTHS | DAYS | 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): Ireland

PARENTS

10. NAME OF FATHER: Unknown

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)

~~Hospital Information~~

14. INFORMANT: E. Rowan
(Address) City Hospital

15. FILED JUN 26 1927 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 24 1927

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1927 to June 24, 1927 that I last saw him alive on June 24, 1927, and that death occurred, on the date stated above, at 2:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ch. Myocarditis
930
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 903
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
8 IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

6/25, 1927 (Signed) [signature], M. D
(Address) City Hospital

*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: Springfield Ill

DATE OF BURIAL: 6-26-1927

20. UNDERTAKER: Alexander & Sons.

ADDRESS: 6135 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.

Becker.