

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

Do not use this space.

25584

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City St. Louis Mo. (No. Baptist Hospital)

File No.
 Registered No. **7180**
 St. Ward)

2. FULL NAME Phillip Heberer

(a) Residence. No. 6503 Dardanelle Pine Lawn Pl. Ward. St. Louis Co. Mo.
 (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) 10/18/1856

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
70 9 19 0 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cigar Maker.
 (b) General nature of industry, business, or establishment in which employed (or employer) Retired.
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

10. NAME OF FATHER Michael Heberer

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

12. MAIDEN NAME OF MOTHER Not Known.

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

14. INFORMANT Jacob Heberer
 (Address) 6303 Dardanelle Pine Lawn

15. AUG - 8 1927 Max G Starckoff
 FILED 19 Starckoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) 8/7/27 19 27

17. Feb 10 1924, to Aug 7 1927
 I HEREBY CERTIFY, That I attended deceased from that I last saw h. son alive on Aug 7, 1927, and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
93° 90 B
117/90 B (duration) 3 yrs. 0 mos. 0 ds.
 CONTRIBUTORY (SECONDARY) Bronchial Pathology
Non Tubercular (duration) yrs. 6 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Phys Ex only

(Signed) Robert Johnson, M. D.

Aug 8, 1927 (Address) Metropolitan Bldg

*State the DISEASE CAUSING DEATH, if 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 Pickers. 8/10/27
 ADDRESS

20. UNDERTAKER Provorosh and Co 3710 N. Grand

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

