

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

Do not use this space.

25591

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(Name)

File No.....

Registered No.....

17187

St. .... Ward)

**2. FULL NAME**

(a) Residence, No. .... St.,  
(Usual place of abode)

Ward.....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

18 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

Single

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

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

Oct 10 - 1868

7. AGE

YEARS 58

MONTHS 9

DAYS 26

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

8. OCCUPATION OF DECEASED

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

Dishwasher

(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)

Austria

PARENTS

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.

AUG - 8 1927 FILED 19

May G. Starceff

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

Aug 5 1927

17.

HEREBY CERTIFY That I attended deceased from June 18 1927 to Aug 5 1927 and that I last saw h. alive on Aug 5 1927 and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Chronic myocarditis

34 CONTRIBUTORY (SECONDARY) Chronic nephritis & sinusitis plus non-alcoholic

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

18 DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) .....

M. D.

, 1927 (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

DATE OF BURIAL

St. Peter Paul

8/9 1927

20. UNDERTAKER

ADDRESS

Elementary Co

2317 S. 4th

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.

Mellerguf