

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

Do not use this space.

25684

**1. PLACE OF DEATH**

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo** (No. ....)

File No. ....

Registered No. **7281**

St. .... Ward)

**2. FULL NAME**

**Infant of Walter O & Mollie Kidney**

(a) Residence. No. **1003 Ershelbueger St.** **15** Ward.

(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) **Aug 10 - 1927**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<b>0</b>	<b>6</b>	<b>2</b>	

**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)  
(c) Name of employer

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

**PARENTS**

10. NAME OF FATHER **Walter O Kidney**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **East St. Louis Ill**  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Mollie Toel**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis Mo**  
(STATE OR COUNTRY)

14. INFORMANT **Walter O Kidney**  
(Address) **1003 Ershelbueger**

15. FILED **JUG 12 1927** **Mau B. Barcoff**  
RECEIVED

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from **Aug 10**, 1927, to **Aug 12**, 1927 that I last saw **alive** on **Aug 12**, 1927, and that death occurred, on the date stated above, at **a.** m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Premature birth (6 1/2 mos)**  
**159 / 61 W**  
(duration) yrs. mos. ds. **1 ds.**  
CONTRIBUTORY (SECONDARY) **161 W**  
(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS. **Size & weight**

(Signed) **M. W. Gausberger**, M. D.

**8/12 1927** (Address) **3019 So Jefferson Ave**

\*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 **St. Matthew's Cemetery** DATE OF BURIAL **Aug 13 1927**

20. UNDERTAKER **Ziegenhan Bros** ADDRESS **2623 Chestnut**

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.

WITH CONTINUING INK—THIS IS A PERMANENT RECORD

