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

Do not use this space.

25756

File No. 7357

Registered No.

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louise Mo. (No. Christian Hosp St. ..... Ward)

2. FULL NAME John Stoser

(a) Residence. No. 4116 Lee Ave St., 10 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 31 - 1883

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	6	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter 186
(b) General nature of industry, business, or establishment in which employed (or employer) 194
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Henry Stoser

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

12. MAIDEN NAME OF MOTHER Caroline Rossloff

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

14. INFORMANT Cornelius Stoser
(Address) 4116 Lee Ave

15. FILED AUG 15 1927 Mau C Darneoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 13 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 3 40 a.m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock + Injuries
Rupture Liver
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Fell From Porch
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Accident
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) ....., M. D

Aug, 19 (Address) Cassville

*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 Bethania

DATE OF BURIAL 8-16-1927

20. UNDERTAKER Hy Heidner Und Co

ADDRESS 1417 N. Market

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.

WRITE WITH INDELIBLE INK—THIS IS A PERMANENT RECORD