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.

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

Do not use this space.

25850

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 7460

City St Louis Mo (No. 2247 St Louis Ave St. ..... Ward)

2. FULL NAME Walter H. Kuse

(a) Residence. No. 2247 St Louis Ave St., 20 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: 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) Oct 3 - 1898

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
28	10	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Machinest
(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 Barnard H Kuse
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ills.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Louise Boeckelman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ills.
(STATE OR COUNTRY)

14. INFORMANT Lillian Kline
(Address) 2247 St Louis Ave.

15. FILED AUG 20 1927, 19..... Max C Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 6, 1927, to Aug 19, 1927 that I last saw him alive on Aug 18, 1927, and that death occurred, on the date stated above, at 12 12 a.m. Aug 19-27

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis
Pulmonary
23A
(duration) 8 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED yes
IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TESTS CONFIRMED DIAGNOSIS? Microscopic Clinical +
(Signed) P B Cappel, M. D
, 19 (Address) 4511 N Newstead 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: Calvary
DATE OF BURIAL: Aug 22 1927

20. UNDERTAKER: Hy Leidner Und Co.
ADDRESS: 1417 N. Market St