

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

Do not use this space.

26155

1. PLACE OF DEATH

County..... Registration District No. **791** File No.....
 Township *St. Louis* Primary Registration District No. **1003** Registered No. **7805**
 City..... (No. *5616*, *Cates Ave*) St. Ward)

2. FULL NAME

William D. Christman
 (a) Residence. No. St. **5** 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widower*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Stella F. Christman*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 28-1891*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
56 4 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Secretary*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer *Meyers Construction Co.*

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *Montgomery Christman*

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

12. MAIDEN NAME OF MOTHER *Philomena Mottin*

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

14. INFORMANT *Miss Stella Christman* (Address) *5616 Cates Ave*

15. CEP FILED *-1 1927* *Max C. Starkloff* Registrar

MEDICAL CERTIFICATE OF DEATH

3
 16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 31* 19 *27*
 17. I HEREBY CERTIFY, That I attended deceased from *Aug 16* 19 *27*, to *Aug 31* 19 *27*
 that I last saw him alive on *Aug 31* 19 *27*, and that death occurred, on the date stated above, at *7:40 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ischaemic nephritis Chr.
131 57B / 27W
118C (duration) *25* yrs. mos. da.
 CONTRIBUTORY (SECONDARY) *Arteriosclerosis (Rheumatism)*
Chronic (duration) yrs. mos. *10* da.

18. WHERE WAS DISEASE CONTRACTED *Home*
 IF NOT AT PLACE OF DEATH?.....
 DID AN OPERATION PRECEDE DEATH? *No* DATE OF *Sept 27*
 WAS THERE AN AUTOPSY? *No*
 WHAT TEST CONFIRMED DIAGNOSIS? *Ur. ex. & Chemic. ex. - Haupt Nach*
 (Signed) *Haupt Nach*, M. D.
 , 19 (Address) *400 Commercial Bldg*

*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 Cemetery* DATE OF BURIAL *9/3 1927*

20. UNDERTAKER *Arthur J. Donnelly* ADDRESS *2039 Wash St*

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.

Commercial

Main 2261

10-1230