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

Do not use this space.

File No. 28325
Registered No. 7819

1. PLACE OF DEATH

County ..... Registration District No. 791
Township ..... Primary Registration District No. 1003
City ..... (No. ISOLATION HOSPITAL St. ..... Ward)

2. FULL NAME John Pahl-Roles

(a) Residence. No. 1458 Tamm St., 18 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 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) Feb. 25 - 1923

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	4	6	6	

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

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

PARENTS
10. NAME OF FATHER John Roles
11. BIRTHPLACE OF FATHER (CITY OR TOWN) MO
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Ora Mack
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

14. INFORMANT John Roles (father)
(Address) 1458 Tamm

15. FILED SEP -2 1927 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept - 1 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1927, to Sept - 1, 1927 that I last saw him alive on Sept - 1, 1927, and that death occurred, on the date stated above, at 6:35 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Poliomyelitis, Acute Anterior,
16 (duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (SECONDARY) —
(duration) — yrs. — mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1458 Tamm

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Laboratory

(Signed) George H Garrison, M. D
, 19 (Address) Isolation 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 Peters Cemetery	Sept 4 1927

20. UNDERTAKER	ADDRESS
Kriegshauser Und Co	4104 Manchester Ave

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.