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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 28762

Township ..... Primary Registration District No. 1003 Registered No. 8603

City St. Louis Mo. (No. Alexian Brothers Hospital ..... Ward)

2. FULL NAME Joseph Laffler

(a) Residence. No. 4916 Reber Place St., 13 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 4 mos. 21 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): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/26/1858

7. AGE: Years 69 | Months 4 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Engineer
(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 Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Canada
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Wife - Anna Laffler
(Address) 4916 Reber Place

15. FILED SEP 18 1927 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/17 1927

17. I HEREBY CERTIFY, That I attended deceased from 10/15, 1925, to 9/17, 1927 that I last saw him alive on 9/11, 1927, and that death occurred, on the date stated above, at 11.45 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
Chronic Nephritis
(duration) 1 yrs. 11 mos. 2 ds.+

CONTRIBUTORY (SECONDARY) Arteriosclerosis, General
Hemiplegia
(duration) 1 yrs. 11 mos. 2 ds.+

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) [signature], M. D
9/17, 1927 (Address) 5600 Arsenal St.

*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: Sept 19 1927

20. UNDERTAKER: E. J. Schnur | ADDRESS: 3125 Lafayette Av.

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.

...UNFADING INK—THIS IS A PERMANENT RECORD