

**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
1003**

File No.....

28820

Township.....

Primary Registration District No.....

Registered No.....

8368

City.....

(No. *City Hospital*)

St. Ward)

2. FULL NAME

(a) Residence. No.....
(Usual place of abode)

St. **23** Ward **Woodriver Hill**

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yr. mos. da. How long in U.S., if of foreign birth? yr. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

6-23-1859

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, ... hrs. or ... min.

68

2

25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Harnessmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Meris Mo

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED

SEP 20 1927

1927

*Hospital of Infirmary
Chesnut
City Hospital
May C. Stankoff
REGISTRAR*

1. MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR)

Dec 18 27

17.

I HEREBY CERTIFY That I attended deceased from *Aug 28* 19*27* to *Sept 18* 19*27* that I last saw him *live on* *Sept 15* 19*27* and that death occurred, on the date stated above, at *11:50 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Chronic myocarditis
Chronic Interstitial nephritis*

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *J. J. ...* M.D.
19*27* (Address) *City 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

Calvary Cem -

Sept. 22 1927

20. UNDERTAKER

ADDRESS

Ziegenhein Bros. 26 23 Cherokee St.

K. E.—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.

THIS IS A PERMANENT RECORD

Vanderpluyzen