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.

28909

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

File No. ..... Registered No. 8482

City: Stheuis Mo (No. 1209 Wilmington St. ..... Ward)

2. FULL NAME Henerich Kade

(a) Residence. No. 1209 Wilmington St., 1 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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-25-1859

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
67	8	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Sausage Maker

(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) Austria Hungary

PARENTS

10. NAME OF FATHER Johann Kade

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Austria Hungary

12. MAIDEN NAME OF MOTHER Frances Mueller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Austria Hungary

14. INFORMANT Amelia Kade. (Address) 1209 Wilmington Stheuis Mo

15. FILED SEP 23 1927 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 22 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1927, to Sept 22, 1927 that I last saw him alive on Sept 22, 1927, and that death occurred, on the date stated above, at 7 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

apoplexy

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) none.

(duration) ..... yrs. ..... mos. ..... ds.

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

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) Alvin E. Turek, M. D

9-22, 1927 (Address) 3016 So Jefferson Stheuis Mo

*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: Sunset Burial Park

DATE OF BURIAL: 9-24 1927

20. UNDERTAKER: Weick Bros 2201 So

ADDRESS: Grand Bl