

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

Do not use this space.

28974  
File No. \_\_\_\_\_  
Registered No. 8537

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis (No. City of St. Louis)

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 2309 A 4 St., 23 Ward.

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**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 \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 9 - 1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
72 | | 15

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Day Labor 17  
(b) General nature of industry, business, or establishment in which employed (or employer) 93  
(c) Name of employer 82

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) Max B. Starckoff  
City of St. Louis

15. FILED SEP 29 1927 Max B. Starckoff REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 27 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 to Sept 27, 1927, that I last saw him alive on Sept 27, 1927, and that death occurred, on the date stated above, at 10:45 A.M.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Cerebral hemorrhage  
Chronic myocarditis  
Chronic interstitial nephritis

CONTRIBUTORY (SECONDARY) Arterio-sclerosis  
Senility

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) Edmund R. Shepidan, M.D.  
(Address) City of St. Louis

\*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 St. Pauls DATE OF BURIAL Sept 27-27

20. UNDERTAKER Fendler Hud Co ADDRESS 7819 Mich

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.

WHILE SUBJECT WITH OBTAINING INK—THIS IS A PERMANENT RECORD

Kalzenberg