

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

Do not use this space.

**30318**

**1. PLACE OF DEATH**

County Jackson  
Towship Frank  
City St. Marys

Registration District No. 399  
Precinct Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. 3824  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

George Gintred  
(a) Residence. No. 4276 Asken St., \_\_\_\_\_ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Male 4. COLOR OF RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-8-27 1927

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

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1927, to 10-9, 1927, that I last saw him alive on 7-10-27, and that death occurred, on the date stated above, at 9:30 P.M.

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>71</u>			

acute pneumonia  
108  
92d of R  
(duration) yrs. mos. 5 da.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired Carpenter  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

CONTRIBUTORY (SECONDARY) Ch. Myocarditis  
(duration) yrs. 3 mos. da.

9. BIRTHPLACE (CITY OR TOWN) Austria  
(STATE OR COUNTRY) \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED Don't know  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? No DATE OF me

10. NAME OF FATHER Unknown

WAS THERE AN AUTOPSY? No

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

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) William A. Myers, M. D.  
10/9, 1927 (Address) 815 Shrewsbury St.

12. MAIDEN NAME OF MOTHER Unknown

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

\*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.

14. INFORMANT St. Marys Hospital  
(Address) 716 G. St.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Not St. Marys DATE OF BURIAL Oct 11-1927

15. FILED 10/10 27 1927 M. M. Brown REGISTRAR

20. UNDERTAKER Ketterle ADDRESS city

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.

PERMANENT RECORD

425 Huntington Road

4334 Hill.

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