

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

Do not use this space.

31723

1. PLACE OF DEATH

County.....

Registration District No. **791**

Towship.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No.

Registered No. **9069**

St.

Ward)

2. FULL NAME

(a) Residence. No. **11835 Schilder**

(Usual place of abode)

23 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **15** yrs. mos. da.

How long in U.S., if of foreign birth? **13** yrs. mos. da.

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 Kristin

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

June 18 1863

7. AGE

YEARS

MONTHS

DAY

IF LESS than 1 day, hrs. or min.

64

3

21

8. OCCUPATION OF DECEASED

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

Copper Smith

(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

10. NAME OF FATHER

Carl Kristin

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Austria

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis, Missouri

14.

INFORMANT (Address)

City Hospital

15.

FILED **OCT 11 1927**

Max B. Starkeoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Oct 9 1927

I HEREBY CERTIFY That I attended deceased from

Sept 27 1927, in *Oct 9 1927*

that I last saw him/her alive on *Oct 9 1927* and that

death occurred, on the date stated above, at *City Hospital*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of stomach.

CONTRIBUTORS (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) Edmund P. Sheridan, M.D.
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

St. Peter & Paul Oct 12 1927

20. UNDERTAKER

ADDRESS

Mr. L. Moydell 1926 Allen

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Kristy