

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

Do not use this space.

32175

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City *Mane Mo* (No.)

File No.
Registered No. **19564**
St. Ward)

2. FULL NAME

Peter Piar
(a) Residence. No. *3936 Miller Place*, *15* Ward.
(Usual place of abode)
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.

(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 *Bova Piar*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 5 - 1985*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>42</i>	<i>7</i>	<i>20</i>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Laborer 231*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Hungary*
(STATE OR COUNTRY)

10. NAME OF FATHER *Nick Piar*

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

12. MAIDEN NAME OF MOTHER *Ljiljana Roth*

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

14. INFORMANT *Boa Piar*
(Address) *3936 Miller Place*

15. FILED *OCT 26 1927* *man & Starkeoff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 25 19 27*

17. I HEREBY CERTIFY, That I attended deceased from *Oct 13*, 19*27*, to *Oct 25*, 19*27*, that I last saw him *live on* *10 - 25 - 1927*, and that death occurred, on the date stated above, at *8:50 pm*.

THE CAUSE OF DEATH WAS AS FOLLOWS:

acute Pulmonary Tuberculosis
(of lungs)
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *31*
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *31*
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS? *clinical & Path. test*
(Signed) *Edw. E. Keiple* M. D.
, 19 (Address) *3860 S. Broadway*

*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 *Missouri Crematory* DATE OF BURIAL *Oct 28 19 27*

20. UNDERTAKER *Amendes H Co* ADDRESS *1718 S. 9th*

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.

