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

Do not use this space.

34664

1. PLACE OF DEATH

County: Carondelet
Township: St. Louis Co.
City: ~~Koch,~~ Mo.
Registration District No.: 1123
Primary Registration District No.: 6248 B
File No.:
Registered No.: 386
(No. ..... St. ..... Ward)

2. FULL NAME Nick Leer

(a) Residence. No. 812 Ann Ave. St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred X yrs. X mos. 14 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Barbara Leer

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1878-11-23

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	48	11	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Watchman
(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): Hungary

PARENTS

10. NAME OF FATHER: Mike Leer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Hungary
12. MAIDEN NAME OF MOTHER: Mary Reinert
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Hungary

14. INFORMANT: R. Koch Hospital Records
(Address) Koch, Mo.

15. FILED Nov. 4, 1927 L. C. Obrock, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov. 3 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1927, to Nov. 3, 1927 that I last saw him alive on Nov. 3, 1927 and that death occurred, on the date stated above, at 3.45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lung Abscess
23A

TB of Lungs (duration) X X yrs. 7 mos. X ds.
CONTRIBUTORY (SECONDARY) ~~Unknown~~
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Unknown
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? X-Ray & Sputum

(Signed) Resident Physician, M. D.
11/3/27 (Address) A. L. Gallant

*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: S. S. Peter & Paul's
DATE OF BURIAL: Nov. 7 1927

20. UNDERTAKER: Wacker Heldede
ADDRESS: 2331 So. Bdway

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County St. Louis — Registration District No. 1123 — File No.
Township Carondelet — Primary Registration District No. 6248 B — Registered No. 386
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Nick Leer
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED FEB 22 1925 L. C. Obrock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 3 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19..... that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lung abscess
T.B. abscess
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) T.B. of lungs
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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