

**MISSOURI STATEBOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

35098

1. PLACE OF DEATH

County.....

Registration District No.....

791

File No.....

Township.....
City St. Louis

Primary Registration District No.....
(No. 716 Bittner Ave)

1003

Registered No. 10248
St. Ward)

2. FULL NAME

(a) Residence. No. 716 Bittner Ave St. 8 Ward. 8

(Usual place of abode) (If nonresident give city or town and State)
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

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

Nov 15-07

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, 4 hrs. or 4 min.

8. OCCUPATION OF DECEASED

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

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis Missouri

10. NAME OF FATHER

Stefan Dzo

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Austria

12. MAIDEN NAME OF MOTHER

Kate Petronic

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Austria

14.

INFORMANT

(Address)

Stefan Dzo
716 Bittner

15.

FILED

NOV 16 1927

Nov 6 Starkoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Nov. 15 1927

17.

I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1927, to Nov 14, 1927 (that I last saw him alive on Nov 14 pm, 1927 and that death occurred, on the date stated above, at 11 pm.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac insufficiency (mitral regurgitation) and (patent aorta)
(duration)..... yrs. mos. 1 ds.

CONTRIBUTORY (SECONDARY)

1 month over due and uremic presolation (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) Wm. G. Knight M. D.

, 19 (Address) 8612 Halls Ferry Rd

*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

Concordia

Nov 16, 1927

20. UNDERTAKER

ADDRESS

Wm. L. May dell

1927 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.

