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

Do not use this space.

38555

File No. 11236

Registered No.

1. PLACE OF DEATH

County

Township

City St Louis (No. 4500 Minnesota Av St. Ward)

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME Fred Wm Hasselbrock

(a) Residence. No. St., 15 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. 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	Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) ~~Feby~~ Jan 28 1852

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	75	10	17	

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

PARENTS

10. NAME OF FATHER F N Hasselbrock

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Louis Schmutzler
(Address) 4500 Minnesota Av

15. FILED DEC 16 1927, 19 Mae C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 15th 1927

17. I HEREBY CERTIFY, That I attended deceased from July 2nd, 1927, to Dec 15th, 1927, that I last saw him alive on Dec 12th, 1927, and that death occurred, on the date stated above, at 7 30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac Hemorrhage (Apoplexy)
7401 10613
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Bronchitis Chronic
non Tubercular
(duration) yrs. mos. ds.

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) Walter A Meyer, M. D

Dec 15th 1927 (Address) 4618 Delmar Blvd

*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 St Trinity — DATE OF BURIAL Dec 18 1927

20. UNDERTAKER Thos N Bridgewater — ADDRESS 1936 St Louis Av

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.

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