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

Do not use this space.

38770

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 11500

Township ..... Primary Registration District No. 1003 Registered No. .....

City St Louis (No. 5403 Easton Ave St. ..... Ward)

2. FULL NAME George L. Faust

(a) Residence. No. 5403 Easton Ave 6 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: Male
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 15 1898

7. AGE: Years 29 | Months 5 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dry Goods Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer Owner

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER John G. Faust
11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Rose B. Heil
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo

14. INFORMANT John G. Faust
(Address) 5403 Easton Ave

15. FILED DEC 23 1927 19 May C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 21st 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1927, to Dec. 21, 1927 that I last saw him alive on Dec. 21, 1927, and that death occurred, on the date stated above, at 3 15 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
9911
(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) 90a
(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? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Theodore Greene M. D
, 19 (Address) 5435 Easton

*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: Calvary | DATE OF BURIAL: Dec 24 1927

20. UNDERTAKER: Chas. L. Stuart | ADDRESS: 5525 Easton Ave

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.

3435 Easton