

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

Do not use this space.

2598

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo (City Hospital)..... St. Ward)

2. FULL NAME

Alfred Paul Fabian
 (a) Residence. No. 3830 Parnell St., 20 Ward. (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

2. 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 Elenore Fabian

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-17-1887

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
40 | 7 | 17

8. OCCUPATION OF DECEASED 1868 10 15
 (a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) Schluter Can Co.
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

10. NAME OF FATHER Henry J. Fabian

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

12. MAIDEN NAME OF MOTHER Ida Maelicke

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

14. INFORMANT Ida Fabian
 (Address) 3830 Parnell St.

15. FILED AN - 5 1928 Mar. 6 Starloff
 REGISTERED

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 - 1928

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 7:50 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Injuries (fracture skull)
Fall to street

CONTRIBUTORY (SECONDARY) Accident
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

3. DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Tom Dwyer M.D.
 15 1928 (Address) Dep Conover

*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
Valhalla Crematory Jan 7 - 1928

20. UNDERTAKER ADDRESS
Provoch Ind Co 3710 N. Grand

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.

WHITE PLAIN, WITH ORANGE

