

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

Do not use this space.
7183

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis* (No. *5095 Ridge*)

Registration District No. *791*
Primary Registration District No. *1003*

File No.....
Registered No. *2161*
St. Ward)

2. FULL NAME

(a) Residence. No. St. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. 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 *Julia Filla*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 25 1864*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
63 2 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer) *Commission Merchant*
(c) Name of employer

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

10. NAME OF FATHER *Gen Filla*

11. BIRTHPLACE OF FATHER (CITY OR TOWN); (STATE OR COUNTRY) *Europe*

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN); (STATE OR COUNTRY) *" "*

14. *Ms Julia Filla*
5095 Ridge

15. *1928*
mdc & Starkeoff
Register

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 26 1928*

17. I HEREBY CERTIFY That I attended deceased from *Sept 29 1927* to *Feb 26 1928* that I last saw *him* alive on *Feb 26 1928*, and that death occurred, on the date stated above, at *5:15 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS
Diabetes Mellitus
59
378 (duration) *6* yrs. *6* mos. *6* da.

CONTRIBUTORY (SECONDARY) *Compulsions* (duration) *4* yrs. *4* mos. *4* da.

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

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *lab. tests*
(Signed) *O. Raines, M. D.*
2/27 1928 (Address) *390 W. No. 10th St.*

*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 *2-29 1928*

20. UNDERTAKER *Arthur J. Donnelly* ADDRESS *2039 Park*

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 MARKET, WITH OUTGOING MAIL THIS IS A PERMANENT RECORD

Dr C. G. Kames

Met Recd

July 5 101.

9-11