

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

Do not use this space.

10813

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City *St. Louis* No. *4477th Papin St* St. _____ Ward _____

File No. _____
 Registered No. **2033**
 St. _____ Ward _____

2. FULL NAME

John C. Paulsell
 (a) Residence No. *4477th Papin* St. *18* Ward _____
 (Usual place of abode)
 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) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 16, 1925*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
2 4 22

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER *John Paulsell*

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

12. MAIDEN NAME OF MOTHER *Hellie Venable*

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

14. INFORMANT *John Paulsell*
 (Address) *4477th Papin*

15. **MAR -9 1928** *Marie Starkoff*
 FILED 19 _____ REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3 - 8 - 1928*

17. I HEREBY CERTIFY That I attended deceased from *in* *3-1* 19*28*, to *3-8* 19*28*, that I last saw h. *alive* on *3-7* 19*28*, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia labor

11A
108
106 C (duration) yrs. mos. *9* da.
 CONTRIBUTORY *Bronchitis* (SECONDARY) (duration) yrs. mos. *10* da.

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

0 DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *James A. Blance*, M. D.

(Address) *2606 Brown*

*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

Rolla Mo *Mar 10* 19 *28*

20. UNDERTAKER ADDRESS *4104*

Kriegshauser & Co. Manchester

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.

