

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

Do not use this space.

11381

**1. PLACE OF DEATH**

County.....  
Township.....  
City *St. Louis, Mo.*

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

File No. ....  
Registered No. *3221*  
St. .... Ward)

**2. FULL NAME**

*Walter Kitterlin*  
(a) Residence, No. *4735<sup>a</sup> McMillan 12* Ward.

(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred *5* 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 *Divorced*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Wabe Smith*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 18 - 1896*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>32</i>	<i>1</i>	<i>3</i>	

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

9. BIRTHPLACE (CITY OR TOWN) *Abilene Texas*  
(STATE OR COUNTRY)

10. NAME OF FATHER *John Kitterlin*

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

12. MAIDEN NAME OF MOTHER *Martha Bruce*

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

14. INFORMANT *Martha Kitterlin*  
(Address) *4735<sup>a</sup> McMillan*

15. FILED *21* *Max E. Starnes*  
19 *1928* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

*2*  
16. DATE OF DEATH (MONTH, DAY AND YEAR) *3 - 21 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 1*, 19*27*, to *March 20*, 19*28*  
that I last saw him alive on *March 20*, 19*27*, and that death occurred, on the date stated above, at *4 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Pulmonary Tuberculosis*

*28* *34* *13A*  
(duration) *6* yrs. mos. da.

CONTRIBUTING (SECONDARY) *Sustic infection*  
(duration) *2* yrs. mos. da.

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

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

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS. *Sputa + Physical Sign*  
(Signed) *Oscar D Meyer*, M. D.  
, 19 (Address) *4665 Jeanon*

\*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 *Detroit - Texas* DATE OF BURIAL *3 - 24 1928*

20. UNDERTAKER *Cullerine Bur* ADDRESS *1712 N. Grand*

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

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.

*1828 9/10/28*

