

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

Do not use this space.

11703

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis*

Registration District No. *791*  
Primary Registration District No. *1003*  
(No. *Lutheran Hospital*)

File No. ....  
Registered No. *3550*  
St. .... Ward

**2. FULL NAME**

*Frank Verderitz*  
(a) Residence. No. *3716 Blair av* St. *26* 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

*Agnes Verderitz*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 15 1871*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*56 9 13*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Cabinet maker*

(b) General nature of industry, business, or establishment in which employed (or employer)

*Park Yon*

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) *Austria Hungary*

**10. NAME OF FATHER**

*Unknown*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) *Austria*

**12. MAIDEN NAME OF MOTHER**

*Unknown*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) *Austria*

**14.**

INFORMANT *Agnes Verderitz*  
(Address) *3716 Blair av.*

**15.**

FILED *30 1928*  
*May C. Starkoff*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-28-28* '19

17. I HEREBY CERTIFY, That I attended deceased from *3-27-28* 19... to *3-28-28* 19... and that I last saw him alive on *3-28-28* 19... and that death occurred, on the date stated above, at *9:00 P.* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*930 arteriosclerotic Heart  
75B Chronic Myocarditis*

(duration) yrs. *3* mos. da.

CONTRIBUTORY (SECONDARY)

*Congestive Failure*

(duration) yrs. mos. da. *6*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH *At Home*

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

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *clinical & Lab.*

(Signed) *Theo. H. Hauser*, M. D.

*3/29*, 19*28* (Address) *3657 Selmer*

\*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

*Miss. Bethlehem*

DATE OF BURIAL

*Mar 31 1928*

20. UNDERTAKER

*Theo. H. Bidornien*

ADDRESS

*1936 A Louis*

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.

EMMENT RECORD

