

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

Do not use this space.

18668

**1. PLACE OF DEATH**

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

Registration District No. *701*  
Primary Registration District No. *006*  
(No. *St. Johns Hospital*)

File No.....  
Registered No. *5057*  
St. .... Word)

**2. FULL NAME**

(a) Residence. No. *4864 Bessie Ave* 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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Male*

4. COLOR OR RACE *White*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 30, 1925*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>2</i>	<i>9</i>	<i>7</i>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *None*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 7 1928*

17. I HEREBY CERTIFY That I attended deceased from *May 7 1928* to *May 7 1928* that I last saw him alive on *May 7 1928*, and that death occurred, on the date stated above, at *1058* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Lymphatic Leukemia*

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

CONTRIBUTORY (SECONDARY) *none* (duration) yrs. mos. da.

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

10. NAME OF FATHER *Michael Nikrant*

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

12. MAIDEN NAME OF MOTHER *Helen Bour*

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

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: *at home*

19. DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *May 1-28*

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Laboratory & Clinical*  
(Signed) *Carl*, M. D.  
*578*, 1928 (Address) *No Theatrical Building*

\*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.

14. INFORMANT (Address) *Michael Nikrant 4864 Bessie Ave*

15. FILED *May 7 1928* Registrar *Max C. Stanley*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Calvary* DATE OF BURIAL *May 10 1928*

20. UNDERTAKER *Math. Hermann & Son* ADDRESS *3950 Carter Ave*

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.

