

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(No. *City Hospital*)

File No.....

18813

Registered No.....

5213

St..... Ward.....

2. FULL NAME

(a) Residence No. *1873 & 9*

(Usual place of abode)

St. *23* Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *27* yrs.

How long in U.S., if of foreign birth? yrs. mos. ds.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

March 19 1879

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

49

1

21

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)

(STATE OR COUNTRY)

Hungary

10. NAME OF FATHER

Audna Fabry

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Hungary

12. MAIDEN NAME OF MOTHER

Mary Louk

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Hungary

14.

INFORMANT

(Address)

City Hospital

15.

FILED

APR 12 1928

Max C. Stankov

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

May 10 1928

17. I HEREBY CERTIFY, That I attended deceased from *May 9*, 19*28*, to *May 10*, 19*28* that I last saw *h. l. r. r.* alive on *May 10*, 19*28*, and that death occurred, on the date stated above, at *7:30* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Robert A. Simpson* M. D.

10, 19*28* (Address) *City Hospital*

*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

Valhalla Cemetery

DATE OF BURIAL

May 12

20. UNDERTAKER

A. N. M. Laughlin

ADDRESS

1631 W.

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.

Fabry