

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

Do not use this space.

18843

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **4500**) **Washington ave.** St. **19** Ward

File No.
 Registered No. **5242**

2. FULL NAME

(a) Residence. No. St. **19** 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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Dec 10 - 1848</i>		
7. AGE - YEARS <i>79</i>	MONTHS <i>5</i>	DAYS <i>1</i>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>labour</i> (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) <i>Germany</i>		
10. NAME OF FATHER <i>Franz Born</i>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>		
12. MAIDEN NAME OF MOTHER <i>Friedricha Born</i>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Germany</i>		
14. INFORMANT <i>Minnie Flottman</i> (Address) <i>4500 Washington ave</i>		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5/11 1928*

17. I HEREBY CERTIFY That I attended deceased from *5/8 1928* to *5/11 1928* that I last saw him alive on *5/10 1928*, and that death occurred, on the date stated above, at *7:15 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
8244 7401
97 (duration) yrs. mos. *3* da.
CONTRIBUTORY (SECONDARY) *Arterio Sclerosis*
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *Home*
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH *no* DATE OF.....
 WAS THERE AN AUTOPSY *no*
 WHAT TEST CONFIRMED *Physical Symptom*
 (Signed) *Chas P. Martin*, M. D.
111, 19*28* (Address) *3903 Rue C*

*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 <i>St. Peters Cemetery</i>	DATE OF BURIAL <i>5-12 1928</i>
20. UNDERTAKER <i>Wm J. Jannasch</i>	ADDRESS <i>1844 N. Jefferson</i>

15. FILED *MAY 12 1928* *Max B. Garces*
 REGISTER

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.

