

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

Do not use this space.

21895
6016

1. PLACE OF DEATH

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

Registration District No. *784*
Primary Registration District No. *1008*

File No.....
Registered No. *6016*
St. Ward

2. FULL NAME

(a) Residence. No. *1840 Dolman St.* *23* Ward.
(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U.S., if of foreign birth? *50* 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 — *Minnie Peroutka* (OR) WIFE OF.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 4, 1875*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Stone Molder*
(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) *Bohemia*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Bohemia*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Bohemia*

14. INFORMANT

(Address) *August Peroutka*
1840 Dolman

15. FILED

JUN -5 1928 *May C. Stanley*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 4, 1928*

17. I HEREBY CERTIFY That I attended deceased from *March 11, 1928* to *June 4, 1928* that I last saw him alive on *June 4, 1928*, and that death occurred, on the date stated above, at *8:15 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS
Atrophic Cirrhosis
(non alcoholic)
124B (duration) *6* yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *124B* (duration) *6* yrs. mos. ds.

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 DIAGNOSIS? *Examination*

(Signed) *Alair E. Tamm*, M. D.

6/4, 1928 (Address) *3014 10th St.*

*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

S. S. Peter & Paul

20. UNDERTAKER

Thos. Kuttis

DATE OF BURIAL

June 7, 1928

ADDRESS

2906 Gravois

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

M. R.—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.

