

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

Do not use this space.

22211

1. PLACE OF DEATH

County St. Louis
 Township _____
 City St. Louis (No. 500 So. Kings Highway St. _____ Ward)

Registration District No. 791

Primary Registration District No. 1003

File No. _____

Registered No. 6393

2. FULL NAME

John Willis Tabak
 (a) Residence No. 313 N. Jefferson Ave. 211 Ward. West Frankfort Ill.
 (Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds.

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)

—

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

—

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

3-10-27

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

1

3

5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____

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

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

West Frankfort, Ill.

(STATE OR COUNTRY)

10. NAME OF FATHER

Harley Tabak

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Critten

(STATE OR COUNTRY)

Ky

12. MAIDEN NAME OF MOTHER

Stella Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Jett Co.

(STATE OR COUNTRY)

Ill.

14.

INFORMANT

(Address)

L. McLeod Hill
500 So. Kings Highway

15.

FILED

16

May C Starkley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

6-15

19 28

17.

I HEREBY CERTIFY, That I attended deceased from 6-12-28 19 28, to 6-15 19 28

that I last saw him alive on 6-15 19 28, and that death occurred, on the date stated above, at 9:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculous meningitis

3200

(duration) _____ yrs. _____ mos. 25 ds.

CONTRIBUTORY (SECONDARY)

Otitis media, acute non-
tuberculous (duration) _____ yrs. _____ mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, home

DID AN OPERATION PRECEDE DEATH? NO... DATE OF...

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Phys. Exam. Spinal fluid

(Signed)

6/15 19 28 (Address) St. B. Childress

*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

DATE OF BURIAL

West Frankfort Ill.

June 17 19 28

20. UNDERTAKER

M. N. Marshall

ADDRESS

Union

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.

