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.

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

Do not use this space.

25273

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 7074

City St. Louis (No. Barnes Hospital St. ..... Ward)

2. FULL NAME Charles ~~Voss~~ Voss.

(a) Residence. No. 1015 Victor St., 23 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb. 2 - 1882

7. AGE: Years 46, Months 5, Days 3. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Auto Trimmer
(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): Ill.

PARENTS
10. NAME OF FATHER: Richard Voss
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ill.
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ill.

14. INFORMANT: Anna Voss
(Address) 1015 Victor St.

15. FILED JUL 7 1928, 19.. Max C. Starling REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 5 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at 3 20 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Shock & Injuries Fractured Skull Due to falling from Shoe Boxes While Accident (duration) ..... da.

CONTRIBUTORY (SECONDARY): Same (duration) ..... mos. ..... da.

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18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. W. Kernan, M.D.
7/6, 1928 (Address) Dep. Coroner

*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: Calvary
DATE OF BURIAL: July 7 1928

20. UNDERTAKER: Walker-Helderle
ADDRESS: 2331 S. Brig