

**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. 03
 City St. Louis, Mo. (No. St. Louis, Mo.) St. _____ Ward _____

File No. 25843
 Registered No. 7699

2. FULL NAME

(a) Residence. No. 8123 Hahn St., _____ Ward _____
 (Usual place of abode)

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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Selma Myers</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>4/20/1888</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>70</u>	<u>3</u>	<u>5</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>Retired 515 108</u>				
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Painting 936</u>				
(c) Name of employer <u>Contractor</u>				

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Denmark

10. NAME OF FATHER Mark

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Denmark

12. MAIDEN NAME OF MOTHER Mark

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Denmark?

14. INFORMANT (Address) Madeline Kehl 8123 Hahn Str.

15. FILED 26 1928 Max C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-25-1928

17. I HEREBY CERTIFY That I attended deceased from June 4 1928 to July 25 1928 that I last saw h. _____ alive on July 25 1928, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS
Coronary Arteriosclerosis
Retention Urine
Uræmia of Uremia
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY (SECONDARY) Pneumonia (Double) Septic Myocarditis Chronic
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
49 NOT AT PLACE OF DEATH.....
 (1) DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) John Campbell, M. D.
 , 19 _____ (Address) 723 W. Main St. St. Louis

*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 <u>Staten Ill.</u>	DATE OF BURIAL <u>7/28/28</u> 19 <u>28</u>
20. UNDERTAKER <u>Abraham & Sons</u>	ADDRESS <u>175 W. Main</u>

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.

Wm. L. ...
... ..