

**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

1003

File No. 28884

28884

Township.....

Primary Registration District No.

Registered No. 8387

8387

City St. Louis

(No. St. Ann's childrens Hospital)

Ward).....

2. FULL NAME

Ralph Hein

(a) Residence. No. 7002 S. West ave, St. 4 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. 1 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

—

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

July 29 - 1923

7. AGE

YEARS

MONTHS

DAYS

5

—

18

If LESS than 1 day, hrs. or min.

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)

St. Louis

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Oswald Hein

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Hellie Kemp

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

St. Louis

Mo.

14.

INFORMANT

Oswald Hein

(Address)

7002 S. West ave

15.

FILED

1928

Max C. Starnoff

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 17 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....., 19.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gunshot wound of abdomen

CONTRIBUTORY (SECONDARY)

184 (duration)..... yrs. mos. da.

Accident

(duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

8 183 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

181 (Signed) R. O. Pitt, M. D.

181 (Address) 1924 Osborne

*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

Oak Hill

DATE OF BURIAL

Aug 20 1928

20. UNDERTAKER

Parker & Co

ADDRESS

Webber Graves

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.

