

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

Do not use this space.

32320

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *St. Johns Hosp*)

File No.
Registered, No. **9634**
St. Ward)

2. FULL NAME

(a) Residence. No. *19 South 16th* St., *25* Ward.

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male | *White* | *Married*

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

Alta

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 2 1870*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min.

57 | *11* | *26*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Rooming house*

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Louisville Ky*
(STATE OR COUNTRY)

10. NAME OF FATHER *John Stenmark*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Louisville Ky*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Mary*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Louisville Ky*
(STATE OR COUNTRY)

14. INFORMANT *Alta Stenmark*
(Address) *19 South 16 St*

15. FILED *30* 19*28* *Max E. Stark* REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9-28-1928*

17. I HEREBY CERTIFY, That I attended deceased from *9-15*, 19*28*, to *9-28*, 19*28* that I last saw him alive on *Sept 28*, 19*28*, and that death occurred, on the date stated above, at *7:55 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chr. Interstitial nephritis
Uremia 131
chronic myocarditis 130
(duration) *8* yrs. *137* ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED? *Montana*
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Gov. mortuary clinic findings*
(Signed) *W. M. Taylor* (M. D.)

, 19 (Address) *945 Mont. Theater Bldg*

*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 *New Albany Ind.* DATE OF BURIAL *9-30-1928*

20. UNDERTAKER *J. P. Murrell's Sons* ADDRESS *1407 Market*

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.

