

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

Do not use this space.

34574

1. PLACE OF DEATH

County.....
 Township.....
 City.....
 Registration District No. **791**
 Primary Registration District No. **1003**
 (No. En Route to City, Hosp # 2)

File No.....
 Registered No. **9948**
 St. Ward

2. FULL NAME

Thomas Hochler
 (a) Residence, No. **1932 Division** St., **21** 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE W	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) unknown		
7. AGE YEARS abt 64	MONTHS ✓	DAYS ✓
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Laborer 117A 129 (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) **Missouri**

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address) **J.W. Kermer**
Coroner Office

15. FILED **OCT 10 1923**
Mar. C. Starkoff
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH
 16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 3 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 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Generalized Peritonitis
Gastric Ulcer
 CONTRIBUTORY (SECONDARY) **117A**

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH:
 8 DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY? **Yes**
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **[Signature]**, M. D.
 10/2, 1928 (Address) **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 **Roller Field** DATE OF BURIAL **10/10 1928**

20. UNDERTAKER **Bales** ADDRESS **4107 Lumber**

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

