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

Do not use this space.

42847

File No. 12113

Registered No.

1. PLACE OF DEATH

County

Township

City St Louis (No. City Hosp #1 St. Ward)

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME Carl Dowander

(a) Residence. No. 617 Walnut St. St., 25 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Abt	50	✓	✓	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer 1866 1948
(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) Sweden

PARENTS

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) UNKNOWN
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT Jos. W. Hemer
(Address) Coroners Office

15. DEC 13 1928 Ray C Sparks
FILED 19 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 8th 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 11:40 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries
Fractured Skull
Accident (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) Fall Down Steps
(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH 615 Walnut St.
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Joseph Shelby ~~M. D.~~
12/13, 1928 (Address) Deputy 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 Potters Field — DATE OF BURIAL 12-14 1928

20. UNDERTAKER Southern — ADDRESS 7315 S. Broadway

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.