

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

Do not use this space.

42931

12201

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **2005**

City **St. Louis** (No. **City of St. Louis**)

File No.

Registered No.

St. Ward)

2. FULL NAME

(a) Residence. No. **1943 Fullerton St. 26** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **13** yrs.

How long in U. S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

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

Female *White* *Single*

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

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

Aug 26 1915

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

13 3 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

Scholarship

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

108 905

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St. Louis

(STATE OR COUNTRY)

10. NAME OF FATHER

Joe Babrows

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Missouri

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Lena Hoker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Missouri

(STATE OR COUNTRY)

14. INFORMANT

(Address)

*ER ...
1001 ...*

15. FILED

1928

Max C. Stahlberg

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 14 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Dec 6*, 1928, to *Dec 14*, 1928, and that I last saw him alive on *Dec 14*, 1928, and that death occurred, on the date stated above, at *11:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia (Septic) acute Pericarditis 2wk.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

12/14/28 (Address) City Hospital

*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

DATE OF BURIAL

Concordia Cem.

12-17-28

20. UNDERTAKER

ADDRESS

267 Lerchner Blvd. St. 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.

Jehans