

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

Do not use this space.

43609

File No. _____
Registered No. 12930
St. _____ Ward _____

1. PLACE OF DEATH

County _____

Registration District No. 791

Township _____

Primary Registration District No. 1003

City St. Louis (No. 14082)

Primary Registration District City Hospital

2. FULL NAME

(a) Residence No. 916 D 2 St. 22 Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

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

Widowed

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

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

May 10 - 1853

7. AGE

YEARS 75

MONTHS 7

DAYS 18

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

Carpenter

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

926 106 16

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

10. NAME OF FATHER

Wass Spiles

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Mary Koatman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

14. INFORMANT

(Address) City Hospital

15. FILED

5 DEC 31 1928 Max C. Stanley REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 28 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1928 to Dec 28 1928 that I last saw him alive on Dec 28 1928 and that death occurred, on the date stated above, at 7:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. Myocarditis
Ch. Bronchitis non
Simility (duration) Tubercular yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. Segg, M.D.

(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

St. Mat. News

DATE OF BURIAL

Dec 31 1928

20. UNDERTAKER

E. J. Jones

ADDRESS

3121 Lafayette

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.

Spies