

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

Do not use this space.

3672

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **Jewish Hosp**) St. (Ward)

File No. **1 210**
Registered No. **210**

2. FULL NAME

Baluy Garden
(a) Residence, No. **2204 Harvard St.** (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. **6** 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 (use the word) single
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan 4, 1929**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ... min.
				2 hrs. or 5 min.

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER **Herman Garden**

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

12. MAIDEN NAME OF MOTHER **Edith Landau**

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

14. INFORMANT (Address) **Max Garden 26401 North Olive St.**

15. FILED -7 1929 **Max C. Gardner** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 4 1929**

17. I HEREBY CERTIFY, That I attended deceased from 1/4/29 @ 8:30 p.m. 1929 to 1929, that I last saw him alive on Jan 7 1929, and that death occurred, on the date stated above, at 10:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

asphyxiation (duration) **159** yrs. mos. ds.
1610 (duration) **1610** yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Hematuria (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? no DATE OF.....

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) **C. E. Keight**, M. D.
1/5, 1929 (Address) **Jewish Hosp**

*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 **Bnai Amoona** **DATE OF BURIAL** **1/7 1929**

20. UNDERTAKER **H. B. Berger** **ADDRESS** **415 McPherson**

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.

