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

Do not use this space.

4189

File No. ..... 7 ..... 8113

Registered No. .....

**1. PLACE OF DEATH**

County ..... Registration District No. 1008

Township ..... A ..... Primary Registration District No. ..... .....

City St Louis. (No. City Hospital ..... St. ..... Ward)

**2. FULL NAME** William Stalle.

(a) Residence. No. Municipal Lodging House 23 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. 1 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 | Widowed |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 8 1878

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 50 | 5 | 18 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Maine
(STATE OR COUNTRY)

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

Mayfield Informant

14. INFORMANT E Rosen
(Address) City Hospital

15. FILED ....., 19.. Mary C Starkloff
REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1929, to Jan 15, 1929, that I last saw him alive on Jan 15, 1929, and that death occurred, on the date stated above, at 3 A.M. P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac Asthma
Ch. Myocarditis
5B (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 9 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? No

0 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) R Berg, M. D.

1/16, 1929 (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 Peters Cemetery — DATE OF BURIAL Jan. 17 1929

20. UNDERTAKER John M. Schumacher — ADDRESS 1844 N Jefferson

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.

THIS IS A PERMANENT RECORD

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Heller