

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

Do not use this space.

4331

**1. PLACE OF DEATH**

City St. Louis Registration District No. 791  
 Township St. Louis Primary Registration District No. 1003  
 No. City Hosp.

File No. \_\_\_\_\_  
 Registered No. 960  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 1416 1/2 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 12 yrs. mos. da. How long in U.S., if of foreign birth 12 yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male  
 4. COLOR OR RACE White  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 30, 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
39

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pollock, Missouri

10. NAME OF FATHER Michael J. Jank

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Pollock, Missouri

12. MAIDEN NAME OF MOTHER Catherine Jank

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Pollock, Missouri

14. INFORMANT (Address) Mrs. Carl Jank, 1416 1/2 St. Louis, Mo.

15. FILED \_\_\_\_\_ REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-18 1929

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 \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Gas Poisoning - Illuminating  
as self administered  
164A

CONTRIBUTORY (SECONDARY) Suicide

18. WHERE WAS DISEASE CONTRACTED (duration) \_\_\_\_\_ yrs. mos. da.  
167

8 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) Wm. J. Dever M.D.  
Capri 179 (Address) Corner

\*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 (CREMATORIUM, OR REMOVAL) DATE OF BURIAL  
St. Rita's Cemetery Jan 27 1929

20. UNDERTAKER ADDRESS  
Spawski & Co. St. Louis, Mo.

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.

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