

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

Do not use this space.

8000

1. PLACE OF DEATH

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

File No.
 Registered No. **1626**
 St. Ward)

2. FULL NAME

(a) Residence. No. Joseph Van Rees St. 21 Ward.
 (Usual place of abode)
 Length of residence in city or town where death occurred 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) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Francis Van Rees
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 3-1864
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 5 29
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Butcher 518
 (b) General nature of industry, business, or establishment in which employed (or employer) 131
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Belgium
 10. NAME OF FATHER unknown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Belgium
 12. MAIDEN NAME OF MOTHER unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Belgium

14. INFORMANT Wm Van Rees
 (Address) 148 Viceroy St
 15. FILED Feb 12 1929 REGISTRAR

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 12 1929
 17. I HEREBY CERTIFY, That I attended deceased from Feb 12 to Feb 12 1929
 & 9 to 28 to Feb 12 1929
 that I last saw him (alive on Feb 12, 1929, and that death occurred, on the date stated above, at 3:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma (Hypernephroma)
Biliary obstruction
Chronic myocarditis
uremia (duration) 1 yrs. 4 mos. 28 ds.

CONTRIBUTORY (SECONDARY) 1
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH at home 2844 Locust
 DID AN OPERATION PRECEDE DEATH? yes DATE OF Jan 13-1929
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS Autopsy
 (Signed) H. G. ... M. D.
 , 19 (Address) St. Johns 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
Park Lawn 2-4 1929
 20. UNDERTAKER ADDRESS
Southern 7315 S. B. Hwy

1928
1864
1919

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 791 File No. _____
 Township _____ Primary Registration District No. 1003 Registered No. 1624
 City St. Louis (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

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

14. INFORMANT _____
 (Address) _____

15. FILED MAY 1 1929 Lucia C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____, and that I last saw him _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary Artery Right Kidney
Information given over phone
by Dr. S. H. P. Long ex Div. of W. S.
10-29 (duration) _____ yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 _____ (Address)

*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 _____ 19 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

0008-5

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Handwritten signature or initials inside an oval.