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

Do not use this space.

8115

1. PLACE OF DEATH

County ..... Registration District No. 201 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 1767

City St Louis Mo (No. 4529 Red Bud Ave St. ..... Ward)

2. FULL NAME Philip F. Denker

(a) Residence. No. 4529 Red Bud Ave St., 10 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 10 - 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	61	6	25	

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

9. BIRTHPLACE (CITY OR TOWN) St Louis Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER J. P. Denker

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

12. MAIDEN NAME OF MOTHER Elizabeth Bergfeld

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Mary A. Denker
(Address) 4529 Red Bud Ave

15. FILED ..... 19 ..... Max C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 5 - 1929

17. I HEREBY CERTIFY, That I attended deceased from October 1, 1928, to Feb 5, 1929 that I last saw b. I M. alive on Feb 5 55 1929, and that death occurred, on the date stated above, at 1 - AM m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Acute Cardiac Dilatation
131
Alcoholic (duration) 95 B yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Sclerosis of Liver and Chronic Brights Dis? (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Exam
(Signed) R C McElvaine M. D
, 19 (Address) 4356 Warne

*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 Johns North
DATE OF BURIAL Feb. 9 1929

20. UNDERTAKER Hy Leidner Und Co
ADDRESS 1417 N. Market St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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