

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

Do not use this space.

8244

**1. PLACE OF DEATH**

County..... Registration District No.....  
Township..... Primary Registration District No.....  
City St Louis (No. 2814 Ohio an)..... St..... Ward.....

File No.....  
Registered No. 1893  
St..... Ward.....

**2. FULL NAME**

William Thomas  
(a) Residence No. 2814 Ohio St. 254 Ward.....  
(Usual place of abode)  
Length of residence in city or town where death occurred 47 yrs. 8 mos. 6 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 Kathryn Thomas

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 2-1881  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
47 8 6

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Laborer  
(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)

10. NAME OF FATHER Frank Thomas

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

12. MAIDEN NAME OF MOTHER Katharin Czech

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

14. INFORMANT Kathryn Thomas  
(Address) 2814 Ohio an

15. FILED..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 8 19 29  
17.

I HEREBY CERTIFY That I attended deceased from Feb 2 1929, to Feb 8 1929 that I last saw h. l. alive on Feb 8 1929 and that death occurred, on the date stated above, at 3 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Lobar Pneumonia  
101W 108  
92 P.  
(duration) yrs. mos. 1 1/2

CONTRIBUTORY (SECONDARY) Aortic Insufficiency  
(duration) yrs. mos. 1 da.

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 Examination  
(Signed) Roland A. Koch, M. D.  
, 19 (Address) 2838 California Ave

\*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 New. Piker DATE OF BURIAL Feb 11 19 29

20. UNDERTAKER Mr. B. Moy dell ADDRESS 1926 Allen

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.

237  
1  
7  
7

