

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

Do not use this space.

12432

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City..... **St. Louis**

(No. **1224**)

High

File No.

Registered No. **2954**

St. Ward)

2. FULL NAME

Erskine Manne

(a) Residence, No. St.,

(Usual place of abode)

Ward. **25**

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da.

How long in U.S., if of foreign birth?

yrs.

mos.

da.

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

Gertrude Manne

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

unknown

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

abt 68

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Dry goods

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Austria

10. NAME OF FATHER

Morris Manne

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Austria

12. MAIDEN NAME OF MOTHER

unk

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Austria

14. INFORMANT

(Address)

Mrs. E Manne

1224 High

15.

FILED **1119 - 8, 1929**

Max C. Stahler

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

3/7 1929

17. I HEREBY CERTIFY, That I attended deceased from **Feb. 15**, 1929, to **March 7**, 1929 that I last saw him alive on **3/7** and that death occurred, on the date stated above, at **2:00 P. M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. myocarditis

(duration) **2** yrs. **1** mos. **7** da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. 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, **examination**

(Signed) **Fris Cohen**, M. D.

3/7, 1929 (Address) **642 Mo. Bldg. St. Louis**

*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

St. Louis

3/8 1929

20. UNDERTAKER

H. B. Berger

ADDRESS

4715 W. McPherson

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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