

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

Do not use this space.

12730

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **16233**)

City **Central Hospital**

File No.
Registered No. **3265**
St. Ward)

2. FULL NAME

(a) Residence. No. **911** St. **22** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred **20** 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 **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 11 - 1888**

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.
40 10 9

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) (STATE OR COUNTRY) **Germany**

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT (Address) **Central Hospital**

15. FILED **MAR 15 1929** 19. **W. C. Starkley**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 12 1929**

17. I HEREBY CERTIFY That I attended deceased from **Jan 26** 1929, to **March 12** 1929 that I last saw him alive on **March 12** 1929 and that death occurred, on the date stated above, at **5:00 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
**Chronic interstitial nephritis
Chronic myocarditis**

CONTRIBUTORY (SECONDARY) **1290** (duration) yrs. mos. ds.

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

19. Did an OPERATION PRECEDE DEATH..... DATE OF.....
WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?
3/17/29 (Signed) Edmund R. Sheridan, M.D.
(Address) **Central 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 **Cabany Cemetery** DATE OF BURIAL **Mar. 16 1929**

20. UNDERTAKER **Central and Co** ADDRESS **1841 Cass**

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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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PARENTS

REGISTER

Miller