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

Do not use this space.

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File No. .....

Registered No. 3276

1. PLACE OF DEATH

County .....

Township .....

City St. Louis (No. 3936 Washington St. ..... Ward)

Registration District No. .....

Primary Registration District No. .....

2. FULL NAME Stanley Rhorer

(a) Residence. No. 3936 Washington St., 19 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	Single

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
Alt.	24	✓	✓	

8. OCCUPATION OF DECEASED

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

(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) Kentucky

PARENTS

10. NAME OF FATHER Hy. Rhorer.

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

12. MAIDEN NAME OF MOTHER Sally Harp.

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

14. INFORMANT Raymond Rhorer
(Address) Lexington Ky

15. FILED MAR 15 1929 Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 7 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 2 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asphyxiation Due to Fuel Gas Poisoning

1 Hr (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Suicide

..... (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) J. W. Kemer, ~~M.D.~~

3/15, 1929 (Address) Dep. Coroner

*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 Lexington Ky.

DATE OF BURIAL 3/18 1929

20. UNDERTAKER Southern

ADDRESS 7315 S. Bdway

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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