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

Do not use this space.

12868

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 3411

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

City St Louis (No. 5800 Arsenal St. ..... Ward)

2. FULL NAME Joseph Smith

(a) Residence. No. 91 Market St., 25 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 25 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)
M	W	widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 15 - 1850

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	78	3	25	

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

9. BIRTHPLACE (CITY OR TOWN) Philadelphia
(STATE OR COUNTRY) Penn.

PARENTS

10. NAME OF FATHER John Smith

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

12. MAIDEN NAME OF MOTHER Christiana Herrigh

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

14. INFORMANT M. B. Marie Effinger
(Address) 5800 Arsenal St.

15. FILED MAR 19 1929 19 Max C. Hamlett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/9/29 19

17. I HEREBY CERTIFY, That I attended deceased from 3/1 ....., 19 29, to 3/9, 19 29 that I last saw him alive on 3/8, 19 29, and that death occurred, on the date stated above, at 1:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
92 D
99
(duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis
(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? .....

(Signed) B. Kiehlbiel, M. D
3/11, 19 29 (Address) 5600 Arsenal

*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
Washington U.	3 - 13 1929
20. UNDERTAKER	**ADDRESS**
Walter Richter	3500 Rutger St

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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