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

Do not use this space.

12936

1. PLACE OF DEATH

County..... Registration District No. 791 1003

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

City ST. LOUIS MO. (No. ST LUKES HOSPITAL St. ..... Ward)

File No.....

Registered No. 3487

2. FULL NAME GERHARD A. PAULY

(a) Residence. No. 6236 ENRIGHT AVE. St., 5 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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	WIDOWED

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) APRIL 27, 1853

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	75	10	23	

8. OCCUPATION OF DEECEASED
(a) Trade, profession, or particular kind of work Ret. HARDWARE MAN.
(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

PARENTS

10. NAME OF FATHER WILLIAM PAULY

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT G. A. Pauly
(Address) 6236 Enright

15. FILED Mar 28 1929 Max C. Sonken REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 19 1929

17. I HEREBY CERTIFY, That I attended deceased from March, 1929, to March 18, 1929, that I last saw h. alive on March 18, 1929, and that death occurred, on the date stated above, at ..... a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ca. of Stomach 46 B
Acidosis 69 B
Anemia 71 B
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 440
..... (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? Diagnosis & Symptoms

(Signed) M. Bab Gestrau, M. D

, 19 (Address) 3720 Washington

*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
Valhalla	March 21 1929
20. UNDERTAKER	**ADDRESS**
Alexander & Sons	6175 Delmar

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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