

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

Do not use this space.

12944

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo. (No. City Hospital) St. (Ward)

File No.
 Registered No. 3495

2. FULL NAME

Charles Lazarus
 (a) Residence. No. 1707 N. 6th St. St. 25 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 15 - 1868

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min.
60 | 4 | 4 |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Waiter
 (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) Vandalia Ill.

PARENTS

10. NAME OF FATHER Joshia Lazarus

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
 (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

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

14. INFORMANT Josephine M. Gregg
 (Address) 1056 Mariposa Denver Colorado

15. FILED..... 19.....
Ray C. Stanley
 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
 to 19....., to 19.....
 that I last saw h..... alive on..... 19....., and that
 death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Lobar
Pneumonia
10% (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1/1/1
 (duration) yrs. mos. ds.

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

18. DID AN OPERATION PRECEDE DEATH..... DATE OF.....

18. WAS THERE AN AUTOPSY.....

18. WHAT TEST CONFIRMED DIAGNOSIS.....

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

3/21, 1929. (Address) Dep. Cora

*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 Sunset Burial Park DATE OF BURIAL 3-21-1929

20. UNDERTAKER Ziegenhein Bros 2628 Cherokee St. ADDRESS

K. 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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