

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

Do not use this space.

13089

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
(No. *4762 Labadie*)

File No.....
Registered No. *3647*
St. Ward)

2. FULL NAME

(a) Residence. No. St. *6* Ward.
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 3rd 1880*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
88 11 21

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

10. NAME OF FATHER *William Harpke*

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) *Germany*

14. INFORMANT (Address) *Mrs. L Harpke 4762 Labadie*

15. FILED 19 *23 1929* *May C Stanley* REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar 24th 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 1* 1927, to *Mar 24* 1929 that I last saw him alive on *Mar 24, 1929* and that death occurred, on the date stated above, at *11:20 a. m.*

93C THE CAUSE OF DEATH* WAS AS FOLLOWS:
93C
950
950 *gun wound left foot non diabetic* (duration) *14* yrs. mos. ds.
CONTRIBUTORY *Arterio sclerosis and Chronic Myocarditis* (duration) *5* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH *Place of death*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF *2/21/29*
WAS THERE AN AUTOPSY? *No*
WHAT TEST CONFIRMED DIAGNOSIS? *gun wound*
(Signed) *William T. Harsche* M. D.

3/21 1929 (Address) *3500 N Grand*

*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 *Calvary* DATE OF BURIAL *3-27 1929*

20. UNDERTAKER *Arthur J. Donnelly* ADDRESS *2039 Wash 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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100 North 2nd St

3500 N Grand

Col 8120

10/1/81