

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

Do not use this space.

13224

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **03**

City **St. Louis** (No. **City of St. Louis**)

File No.....
Registered No. **3786**
St. Ward)

2. FULL NAME

(a) Residence. No. **2301 R & 11** St. **23** Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred **5 1/2** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** | **4. COLOR OR RACE** **White** | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** **married**

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND or (OR) WIFE **Husana Pfeiffer**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 3 - 1883**

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.
45 | **11** | **23**

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Sheet metal worker**
(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) **Austria Hungary**

10. NAME OF FATHER **Jacob Pfeiffer**

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

12. MAIDEN NAME OF MOTHER **Mam Miller**

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

14. INFORMANT.....
(Address) **West 1001 1/2 St. St. Louis**

15. FILED **1323** **19** **Mar 11** **1929**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 26 1929**

17. I HEREBY CERTIFY That I attended deceased from **March 9**, 19**29**, to **March 26**, 19**29**, that I last saw him live on **March 25**, 19**29**, and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary tuberculosis
2 1/2 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) **3 1/2** (duration) yrs. mos. da.

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) **Henry C. Westerman** M.D.
27, 19**29** (Address) **City of St. Louis**

*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 **St. Peter and Paul** | **DATE OF BURIAL** **March 29 1929**

20. UNDERTAKER **Armeda H. Co** | **ADDRESS** **1718 S 9th St.**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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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