

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.

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

Do not use this space.

APR 30 1929

15723

1. PLACE OF DEATH

County St. CharlesRegistration District No. 757Township St. CharlesPrimary Registration District No. 3036City St. Charles(No. 730 Monroe St.)

File No. _____

Registered No. 59

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 730 Monroe St. _____ 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)

Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 28-1928

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

46

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none Infant.

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Charles Mo.(STATE OR COUNTRY) Missouri10. NAME OF FATHER Mark J. Anderson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ohio12. MAIDEN NAME OF MOTHER Maquet O'Malley13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis Mo.

(STATE OR COUNTRY)

14. INFORMANT Mark J. Anderson(Address) St. Charles Mo.15. FILED 4/6, 1929 By G. Bloebaum

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 4 1929

17.

I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to April 4, 1929.
that I last saw him alive on April 4 15 P., 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Suspect Pharyngeal Disease
Staphylococcus
607

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

not known

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? clinical symptoms(Signed) B. P. Westphal, M. D.4-5, 1929 (Address) St. Charles Mo

*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

Calvary CemeteryApril 6 1929

20. UNDERTAKER

ADDRESS

H. A. Allen & Sons800 N. 2nd St.

