

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis**

(No. **4031**) **Camelia Ave.** St. **16016** Ward

File No. **16016**

Registered No. **4040**

2. FULL NAME

Herbert H. Helling

(a) Residence. No. **4031 Camelia Ave.** St. **16016** Ward. (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da.

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 (write the word) **single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb. 27, 1929.**

7. AGE YEARS MONTHS DAYS **8** If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **at Home**
(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) **Missouri**

10. NAME OF FATHER **Richard H. Helling**

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

12. MAIDEN NAME OF MOTHER **Oliver Smith**

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

14. INFORMANT **Richard H. Helling**

(Address) **4031 Camelia Ave.**

15. FILED **1929** **May 10** **St. Louis**

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 **4/3/29** to **4/4/29** that I last saw him alive on **4/4/29** and that death occurred, on the date stated above, at **12:50 p.m.**

THE CAUSE OF DEATH WAS AS FOLLOWS:

Erysipelas
15 B
(duration) yrs. mos. da. **5**

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? **No.** DATE OF

20. WAS THERE AN AUTOPSY? **No.**

21. WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **Sam J. Baxend**, M. D.

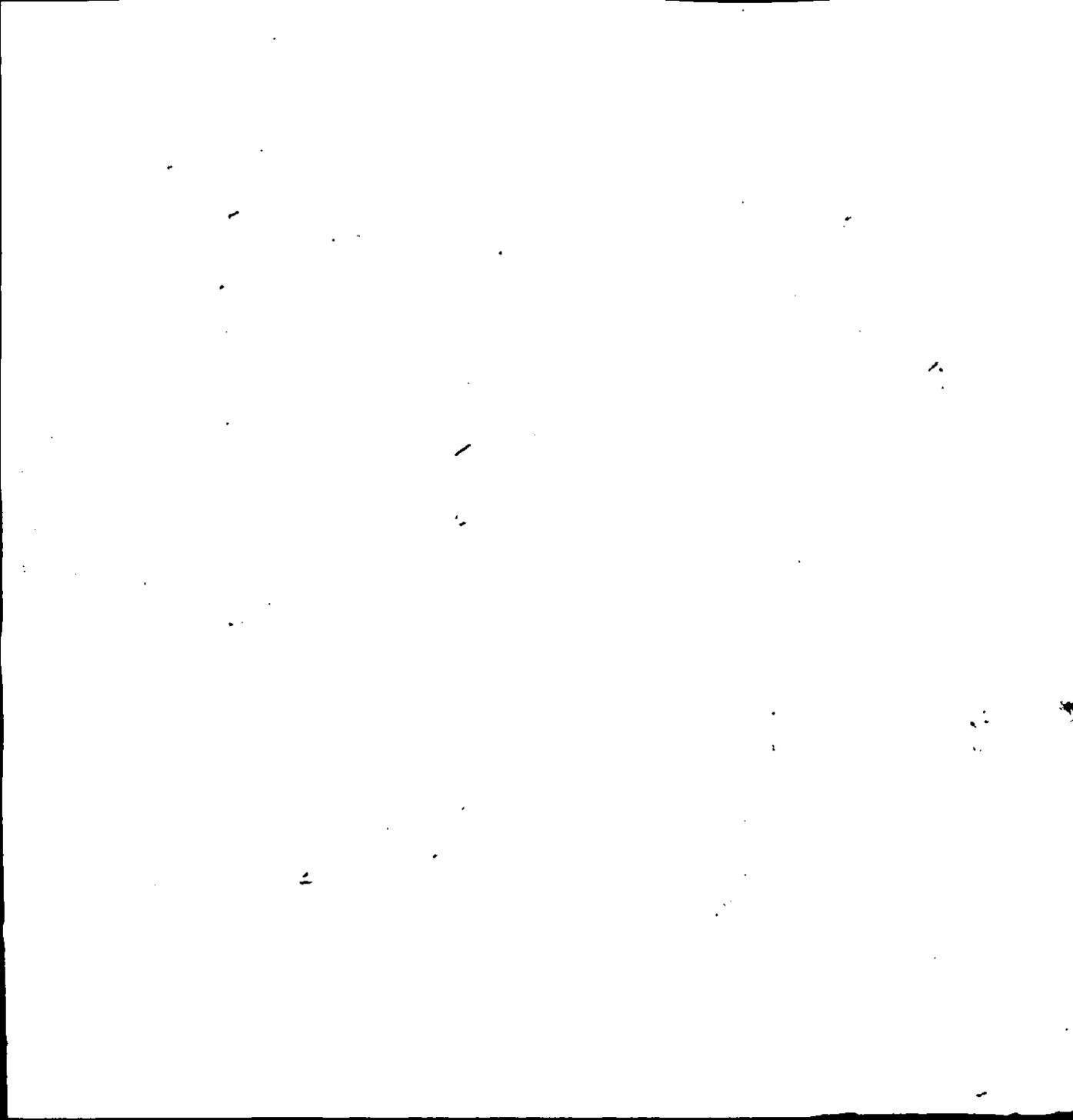
4/4/29 (Address) **5427 Delmar**

*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. Clair No.** DATE OF BURIAL **April 6, 1929.**

20. UNDERTAKER **Joe W. Clark** ADDRESS **1125**

Wodiamont Ave.



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 791 File No. _____
 Townshp. _____ Primary Registration District No. 1003 Registered No. 4070
 City St. Louis (No. _____) St. _____ (Ward)

2. FULL NAME

Herbert H. Helling
 (a) Residence. No. _____ 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) s

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT _____
 (Address) _____

15. FILED JUN 28 1929 Ray C. Starker
 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from _____
 19 _____ to _____ 19 _____
 that I last saw h. _____ alive on _____, 19 _____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Cerebral edema of whole body, non-traumatic cause
information given over
by Dr. Sam Bassett (duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Div. of W. St. 6-18-29
 (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) Sam Bassett, M. D.

, 19 _____ (Address) _____

*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 _____ 19 _____

20. UNDERTAKER _____

ADDRESS _____

SUPPLEMENTARY

5-16016