

**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. 78

File No. 16790

Township

Primary Registration District No. 700

Registered No. 4910

City St. Louis

(No. Allexan Bross St. 2 Ward)

2. FULL NAME

(a) Residence. No. 3510 Nebraska 24 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-11-1868

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>60</u>	<u>5</u>	<u>15</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cabinet maker
(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) Germany

10. NAME OF FATHER Adolph Seitz

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

12. MAIDEN NAME OF MOTHER Marie Beck

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

14. INFORMANT Elizabeth Seitz
(Address) 3510 Nebraska

15. FILED APR 29 1929 May C. Stender REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-26 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1929 to April 26, 1929 that I last saw him alive on April 26, 1929, and that death occurred, on the date stated above, at 2:15 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lymphosarcoma
535

(duration) 3 yrs. mos. ds.

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

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

DID AN OPERATION PRECEDE DEATH? no. DATE OF.....

WAS THERE AN AUTOPSY? no.
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) Robert Reiderer, M. D.

4/28, 1929 (Address) 1012 Sayeraw

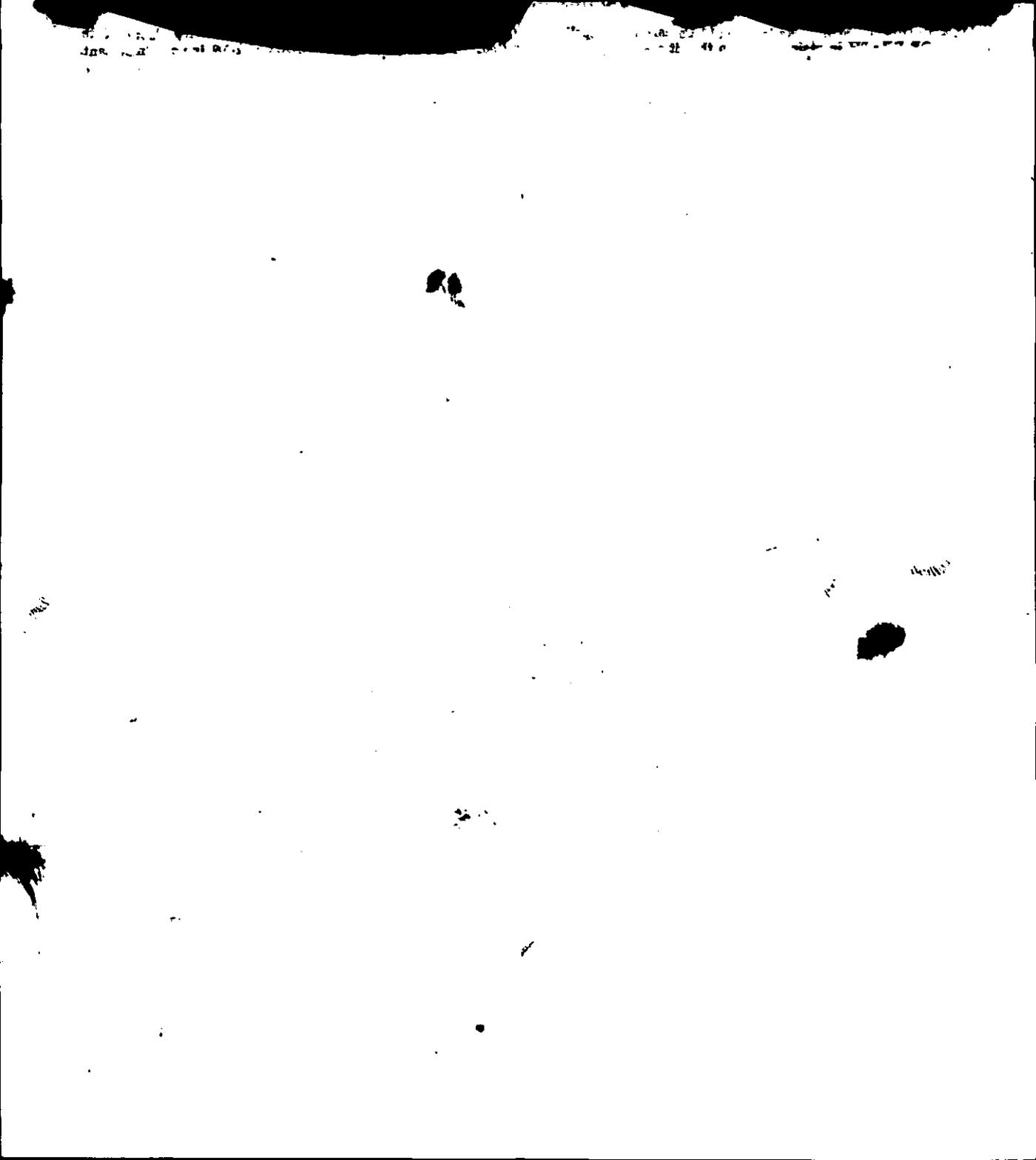
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Peter & Paul DATE OF BURIAL 4-29 1929

20. UNDERTAKER Weick Bros 2201 ADDRESS St Louis

Every item of information should be carefully supplied. A CAUSE OF DEATH in plain terms, so that it may be properly classified. INFORMATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 491 File No.....
 Township..... Primary Registration District No. 1003 Registered No. 4910
 City St. Louis (No.) St. Ward.....

2. FULL NAME

(a) Residence. No. Jacob Seitz 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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. ormin.

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 Max C. Parkington REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/26 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:

Dysentery, acute, bacterial
Primary, acute axillary gland
infection given over phone
by Dr. Rott, Underer (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 9-20-1929 Div. of V.I.B. (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) Frank S. O. O'Brien 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

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH SHARP PENCIL. THIS IS A PERMANENT RECORD.
 The information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-16790