

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

Do not use this space.

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.

JUL 2 1929
 199
 20
 31

PLACE OF DEATH
 County Buchanan Registration District No. 85
 Townshp. St Joseph Primary Registration District No. 1001
 City St Joseph (No. Mo Methodist Hospital)
 Registered No. 584 St. _____ Ward)

2. FULL NAME M. L. Broude
 (a) Residence. No. 731 S 9th 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.

17286

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M	4. COLOR OR RACE Jewish	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>About Unknown 1866</u>		
7. AGE YEARS 63	MONTHS Unknown	DAYS Unknown
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Jewish Rabbi (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) Poland		
10. NAME OF FATHER Unknown		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY)		
12. MAIDEN NAME OF MOTHER Unknown		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY)		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 3 1929**
 17. I HEREBY CERTIFY, That I attended deceased from April 26, 1929 to May 3, 1929 that I last saw h. i. m. alive on April 26, 1929, and that death occurred, on the date stated above, at 4. A. M. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremia
137
132B
 (duration) 1 yrs. 0 mos. 0 ds.
 CONTRIBUTORY **Hypertrophied Prostrate**
 (SECONDARY) (duration) 3 yrs. 0 mos. 0 ds.
 18. WHERE WAS DISEASE CONTRACTED 1355
 IF NOT AT PLACE OF DEATH. **No**
 DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____
 WAS THERE AN AUTOPSY? **No**
 WHAT TEST CONFIRMED DIAGNOSIS **Clinical**
 (Signed) Charles Greenlee M. D.
5/3, 1929 (Address) **P & S Bldg**

*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 Shaare Sholem Cem	DATE OF BURIAL May 5 1929
20. UNDERTAKER Fleeman Funeral Home	ADDRESS 1208 Floriss

14. INFORMANT Mrs F. Broude
 Address 731 So 9th
 15. FILED 6 1929
John G. [Signature] REGISTRAR

