

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

Do not use this space.

22578

PLACE OF DEATH MOUNT ST. ROSE

County GARONDELET
 Township GARONDELET
 City Mount St. Rose

Registration District No. 1123

Primary Registration District No. 6248

File No. _____
 Registered No. 237
 St. _____ Ward _____

2. FULL NAME Andrew J. Hartzell
 (a) Residence No. _____ St. _____ Ward East St. Louis 24
 (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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 8, 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
56 0 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work mechanic
 (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) Arkansas

10. NAME OF FATHER ?

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

12. MAIDEN NAME OF MOTHER ?

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

14. INFORMANT Mr Hartzell (low)
 (Address) East St. Louis Ill

15. Quincy 29 L. C. Abrod
 Filed _____ 19 _____ REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-20-29

17. I HEREBY CERTIFY, That I attended deceased from 6-11-29, 1929, to 6-20-29, 1929, that I last saw him alive on 6-20-29, 1929, and that death occurred, on the date stated above, at 3:25 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CHRONIC PULMONARY TUBERCULOSIS

CONTRIBUTORY (SECONDARY) TUBERCULOUS ENTERITIS

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? various

(Signed) Andrew C. Priske, M. D.

, 19 (Address) Mount St. Rose

*State the DISEASE CAUSING DEATH (or in death from _____ CAUSE OF DEATH (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Resident Physician

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
East St. Louis Ill. June 22 1929

20. UNDERTAKER ADDRESS
H. W. Niederfeld, East St. Louis, Ill.

96
 JUL 27 1929
 N. B.—Every item of information should be carefully supplied. AGE and CAUSE OF DEATH in plain terms, so that it may be properly classified. 31
 60
 2
 31

... and ...
... to ...
... of ...

15 1000

**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 St. Louis Registration District No. 1123 File No. _____
Township Carondelet Primary Registration District No. 6248 E Registered No. 237
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Andrew J. Hartwell
(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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>M</u> <small>(write the word)</small>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept 8 - 1893</u>		
7. AGE YEARS <u>35</u>	MONTHS <u>9</u>	DAYS <u>12</u>
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) _____

PARENTS	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 Oct 3 1919 L. C. Abrock M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-20-1929
17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ (duration) _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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) _____, 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

REGISTRARS should (initial) that it may be properly classified. THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-22578