

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

Do not use this space.

23271

1. PLACE OF DEATH

County..... Registration District No. **791**
 Townshp..... Primary Registration District No. **1003**
 City St Louis Mo (No. City Summary)

File No.....
 Registered No. **6747**
 St. Ward

2. FULL NAME

(a) Residence. No. 5800 Arsenal St., 13 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) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 1854
 YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
7-4 Unknown

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). Labor
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Houston Texas
 (STATE OR COUNTRY)

PARENTS
 10. NAME OF FATHER John Thomas
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo
 12. MAIDEN NAME OF MOTHER Thomas
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) ?

14. INFORMANT Miss Effinger
 (Address) 5800 Arsenal

15. FILED JUN 25 1929 Walter C. Stiller REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 2nd 1929

17. I HEREBY CERTIFY, That I attended deceased from 7/5 1929 to June 2nd 1929 that I last saw him alive on 6/2 1929 and that death occurred, on the date stated above, at 10:25 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia
1872
 (duration) yrs. mos. ds. 2

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

18. WHERE WAS DISEASE CONTRACTED 5800 Arsenal St
 IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? no DATE OF no
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS none
 (Signed) Benj Margulies, M. D.
6/3 19 29 (Address) 5800 Arsenal

*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. Louis U. DATE OF BURIAL 6-4 1929

20. UNDERTAKER Walter Richter ADDRESS 3500 Rutgerst

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.

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