

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. **791**  
**1003**  
Primary Registration District No. **2029 Lane Ave**

File No. **25940**  
Registered No. **7121**  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence No. **757 DuBoulay St.** Ward. **12**  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>M.</b>	4. COLOR OR RACE <b>W.</b>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <b>Widower</b>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Emma Ruth Benth</b>			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <b>7-20-1860</b>			
7. AGE YEARS <b>68</b>	MONTHS <b>11</b>	DAYS <b>16</b>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <b>Lawyer</b> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer			

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **7-6-29** 19**29**

17. I HEREBY CERTIFY, That I attended deceased from **May 14** 19**29** to **July 4** 19**29** that I last saw him alive on **July 4** 19**29**, and that death occurred, on the date stated above, at **5 A.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Carcinoma of pharynx**  
**45F**

(duration) yrs. **4** mos. ds.

CONTRIBUTORY (SECONDARY) **440**  
(duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

10. NAME OF FATHER **Hub**

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

12. MAIDEN NAME OF MOTHER **Hub**

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

14. INFORMANT (Address) **J. J. Epstein 1308 1/2 Hawthorn St.**

15. FILED **JUL -7 1929** **W. C. Family** REGISTRAR

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

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

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) **W. S. Weid** M. D.  
**7/6** 19**29** (Address) **Kirkwood Mo.**

\*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 **Valhalla Cem. 7/8/29** 19  
DATE OF BURIAL

20. UNDERTAKER **Wanda & Sons 175 1/2** ADDRESS

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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Dr. D. S. Weith

