

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

Do not use this space.

29125

1. PLACE OF DEATH

County..... Registration District No. 701
Township..... Primary Registration District No. 1403
City St. Louis (No. City 1000)

File No.....
Registered No. 8250
St. Ward)

2. FULL NAME

(a) Residence. No. 3529 1/2 St., 24 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 15 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 22, 1904

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>25</u>	<u>1</u>	<u>17</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Surgeon
(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) Kentucky

10. NAME OF FATHER Herbert Rubelman

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

12. MAIDEN NAME OF MOTHER Anna Moor

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

14. INFORMANT (Address) City 1000

15. FILED 2 19 24 REGISTRAR Max R. Barker

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9 1924

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1924 to Aug 9 1924 and that I last saw h. live on Aug 9 1924 and that death occurred, on the date stated above, at 10:01 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Strangulation of lower
intestine due to omental
adhesions -
Intestinal obstruction
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? 1810
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 8/5/24 8/8/24
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? Clinical - op. - autopsy
(Signed) Edward Melby, M.D.
8/10 1924 (Address) City 1000

*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
Sunset Burial Pk. 8-12-1924

20. UNDERTAKER ADDRESS
Ziegenhein Bros. 2625 S. Weber

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.

Gullman