

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

Do not use this space.

34934

1. PLACE OF DEATH
 County St. Louis Registration District No. 789
 Township Central Primary Registration District No. 6033 B File No. _____
 City St. Louis (No. 3718) Jennings Rd St. _____ Ward _____
 Registered No. 313

2. FULL NAME Edward C Kasper
 (a) Residence. No. 6411 St. Louis 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 male
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 14 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
56 3 22

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Carpenter 19 93
 (b) General nature of industry, business, or establishment in which employed (or employer) 1706
 (c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 6 19 29

17. I HEREBY CERTIFY, That I attended deceased from _____, 19 _____, to Oct. 6, 19 29 that I last saw him alive on October 6, 19 29, and that death occurred, on the date stated above, at _____ 2:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebro-spinal Paresis, complete optic atrophy, muscular atrophy of all extremities, Paralytic cough, taking complete _____ (duration) Several years da.
 CONTRIBUTORY (SECONDARY) Hypostatic Pneumonia, Bowel Stenosis, Incontinence of urine, Wrenia (duration) 1 yrs. 4 mos. 1 da.

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 clinical
 (Signed) Luke B. Pierson M. D.
10/6, 19 29 (Address) 3718 Jennings Rd
 *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 Zions Cemetery DATE OF BURIAL 10-9 1929
 20. UNDERTAKER Geo. L. Pleitsch ADDRESS 5966 Eastern

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

10. NAME OF FATHER Geo. Kasper

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

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Don't know

14. INFORMANT Mrs. Elsie Goodde (Address) 6101 Marysaretta Ave

15. FILED 10/7/29 Rolla Bray M.D. REGISTRAR

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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