

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

Do not use this space.

35534

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis*

(No. *5370 Pershing Ave.*)

File No.

Registered No. **10285**

St.

Ward)

2. FULL NAME *Gustave S. Kann*

(a) Residence. No.

St. *12*

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)

Married

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

Sadie Kann

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

Jan. 19, 1862

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

67

9

—

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

Insurance Agent

(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)

Baltimore Ma.

10. NAME OF FATHER

Sol. J. Kann

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

Germany

12. MAIDEN NAME OF MOTHER

Caroline Steiner

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

Germany

14.

INFORMANT

(Address)

*Sadie Kann
5370 Pershing*

15.

FILED

OCT 21 1929

*Max C. ...
REGISTRAR*

MEDICAL CERTIFICATE OF DEATH

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

Oct. 19 1929

17.

I HEREBY CERTIFY, That I attended deceased from *Oct. 10*, 19*29*, to *October 19*, 19*29*, that I last saw him alive on *Oct. 19*, 19*29*, and that death occurred, on the date stated above, at *2:30 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS

*Myocarditis, Chronic.
Nephritis, Chronic.
936
97*

CONTRIBUTORY (SECONDARY)

Arteriosclerosis (duration) *5* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRAILED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

*Physical Exam
Herual M. Meyer, M. D.
10-20, 1929 (Address) 601 Metropolitan Bldg.*

*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

Mt. Sinai Cemetery

Oct. 21 1929

20. UNDERTAKER

ADDRESS

H. Rindschopf

*5716
Delmar*

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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1. 250