

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

Do not use this space.

35862

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **7003**

City.....

(No. **10666**)

File No. **10666**

Registered No. **10666**

St.

Ward)

2. FULL NAME

(a) Residence. No. **1439 23**

St. **23**

Ward.

Length of residence in city or town where death occurred **14** 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 MEDICAL CERTIFICATE OF DEATH

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

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

July 24 1897

7. AGE

YEARS *32*

MONTHS *3*

DAY *5*

IF LESS than day, hrs. or min.

8. OCCUPATION OF DECEASED

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

Laborer

(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)

Missouri

10. NAME OF FATHER

Erman Silver

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Mary Kilgerson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14. INFORMANT

(Address)

City of St. Louis

15. FILED **30 1929**

19

REGISTRAR

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 29 1929*

17. I HEREBY CERTIFY: That I attended deceased from *Oct 19* to *Oct 29* 19*29* that I last saw him alive on *Oct 29* 19*29* and that death occurred, on the date stated above, at *1839 So. 3rd St.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Corrosion of Liver (Syphilitic) with abscess
1845 (duration) yrs. mos. *15* ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

1839 So. 3rd St

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Wasserman
Ben Margulies M. D.

129 19 *29* (Address) *City of St. Louis*

*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

Calvary Pro

10-31-29

20. UNDERTAKER

ADDRESS

W. Schumacher

3013

WHITE PEARL GINK--THE PERMANENT RECORD

N. B.—Every item of information supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Sperry

at the office of
the Hon. J. Bell

Proprietor

1864

1864

1864

1864

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 791 File No.....
 Township..... Primary Registration District No. 1003 Registered No. 10666
 City St Louis (No.....) St..... Ward.....

2. FULL NAME

(a) Residence. No. Roy Silvey 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) odd jobs
 (c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT..... (Address)

15. FILED DEC 24 1929 Roy C Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 29 1929

17. I HEREBY CERTIFY That I attended deceased from..... 19..... to..... 19..... that I last saw him..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY)

..... (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*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

20. UNDERTAKER Wm Schumacher 303 W. ... ADDRESS

N. E.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, properly classified. Exact statement of OCCUPATION is required. REGISTRARS SHALL NOT RECEIVE FEES FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

1929
35862