

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

Do not use this space.

38814

1. PLACE OF DEATH

County.....

Registration District No. 791

File No. 11244

Township.....

Primary Registration District No. 1003

Registered No. 11244

City St. Louis (No. Embassy District)

530 N. Union

St. 12 (Ward)

2. FULL NAME

Adam Wackman

(a) Residence. No. 530 N. Union St. 12 Ward.

(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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Minette Wackman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-9-1849

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>80</u>	<u>10</u>	<u>9</u>	

8. OCCUPATION OF DECEASED

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

(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) Indiana

10. NAME OF FATHER Charles Wackman

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Karl G. Wackman
(Address) 4945 Buckingham Ct.

15. FILED NOV 18 1929 Max C. Fowler
19..... REGISTAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 18 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1929, to Nov. 17, 1929, that I last saw him alive on Nov. 17, 1929, and that death occurred, on the date stated above, at 12-40 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of stomach
H.L.R.

(duration) 1 yrs. ? mos. ? ds.

CONTRIBUTORY (SECONDARY) None

(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? X-ray of stomach
(Signed) Red Seal, M. D.

11-18, 1929 (Address) 3701 Westminster Pl.

*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 <u>St. Peters Cemetery</u>	DATE OF BURIAL <u>Nov. 19 1929</u>
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20. UNDERTAKER <u>Alexander & Sons</u>	ADDRESS <u>6175 Dehman</u>
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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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3701 Westchester
dir 68-85