

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

Do not use this space.

42301

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No.

Registered No. **12023**

St. Ward)

2. FULL NAME

(a) Residence. No. **2923** **Indiana** St., **24** 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 **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 **Josephine Cizek**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Mar 13 1881**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **48 8 26**

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work **Painter** (b) General nature of industry, business, or establishment in which employed (or employer) **House** (c) Name of employer

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

10. NAME OF FATHER **Unknown**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **Josephine Cizek** (Address) **2923 Indiana, a**

15. FILED **DEC 10 1929** **Wm C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec. 9 1929**

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19..... and that death occurred, on the date stated above, at **12 P.M.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: **12 P.M.**
Carbolic Acid Poisoning
17920
Whether accidental or intentional not ascertained (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **1777** (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 **No**

WHAT TEST CONFIRMED DIAGNOSIS (Signed) **J. W. Corne** M.D. **12/10 1929** (Address) **Dept. Corone**

*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 **S. S. Peter & Paul** DATE OF BURIAL **Dec. 11 1929**

20. UNDERTAKER **Wm. J. Moydell** ADDRESS **1926 Allen**

WHITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.

X. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS also CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo

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