

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

Do not use this space.

3039

1. PLACE OF DEATH

County.....
Township.....
City..... *Solomon*

Registration District No. *791*
Primary Registration District No. *10033*
(No. *Bethesda Hospital*)

File No.....
Registered No. *524*
St. Ward)

2. FULL NAME

(a) Residence. No. *1814 Oregon Ave St. 23* 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) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 20 - 1929*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<i>X</i>	<i>1</i>	<i>25</i>	

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

9. BIRTHPLACE (CITY OR TOWN) *Solomon*
(STATE OR COUNTRY) *Mo.*

10. NAME OF FATHER *Frank Faust*

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

12. MAIDEN NAME OF MOTHER *Hedys Weiss*

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

14. INFORMANT *Frank Faust*
(Address) *1814 Oregon Ave*

15. FILED *JUN 16 1930* *Wm C. Sturley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 15 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 12* 1930 to *Jan 15* 1930 that I last saw him alive on *Jan 7 1930* and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Convulsions (Cause not known)
910 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *SO* (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) *Ernest J. Doffner* M. D.
, 19 (Address) *211 Tipton 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 *St. Peter & Paul* DATE OF BURIAL *1-17-1930*

20. UNDERTAKER *Peety Cross* ADDRESS *3029 Lafayette*

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.

WRITE PEAINLY WITH UNPADING INK---THIS IS A PERMANT RECORD

Ar. 4 miles copy

Linter 16/17

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