

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

Do not use this space.

6223

1. PLACE OF DEATH

County St. Louis Registration District No. 786
 Township Central Primary Registration District No. 4469
 City Maplewood (No. 2114 Bellview)

File No. _____
 Registered No. 13 St. _____ Ward)

2. FULL NAME

Joseph Maul

(a) Residence No. 2114 Bellview 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

2 MEDICAL CERTIFICATE OF DEATH

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Caroline Maul</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar 9 1858</u>		
7. AGE	YEARS <u>70</u>	MONTHS <u>11</u>
	DAYS <u>11</u>	If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Insurance Agent</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1180 958</u> (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) <u>Alton</u> (STATE OR COUNTRY) <u>Ill</u>		
PARENTS	10. NAME OF FATHER <u>Antoine Maul</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Germany</u> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Germany</u> (STATE OR COUNTRY)	
14. INFORMANT <u>Caroline Maul</u> (Address) <u>2114 Bellview</u>		
15. FILED <u>7/21</u> 19 <u>30</u> <u>Mercedes Schuster</u> REGISTRAR		

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/20 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ that I last saw him alive on 7/20 at 12:00 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Cordone
Dehydration
 (duration) yrs. mos. ds.
Acute Induration
Bacterial Dehydration
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) W. H. Russell, M. D.
7/21/30 (Address) West 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
Calvary Cemetery DATE OF BURIAL 7/21 1930

20. UNDERTAKER
Broghan Und Co - 714 1/2 Manchester
 ADDRESS

MAP 28 1930

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County St. Louis Registration District No. 486 File No.
 Township Primary Registration District No. 4469 Registered No. 13
 City Maplewood St. Ward)

2. FULL NAME Joseph Maul
 (a) Residence No. 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				MEDICAL CERTIFICATE OF DEATH	
3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>M</u> (write the word)		16. DATE OF DEATH (MONTH, DAY AND YEAR) <u>2/20 1930</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				17. I HEREBY CERTIFY, That I attended deceased from 19....., 19....., to 19....., 19....., and that I last saw him alone on 19....., and that death occurred, on the date stated above, at m.	
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar 9-1858</u>				THE CAUSE OF DEATH* WAS AS FOLLOWS:	
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.	
<u>71</u>	<u>10</u>	<u>11</u>	 (duration) yrs. mos. ds.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.	
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				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)	
10. NAME OF FATHER				*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.	
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)				19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL	
12. MAIDEN NAME OF MOTHER			 19	
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)				20. UNDERTAKER ADDRESS	
14. INFORMANT (Address)					
15. FILED <u>2/21 1930 Mercedes Schuster</u> REGISTRAR					

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-6223