

Farber

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

Do not use this space.

6685

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
No. *4157* *Easton*

File No.....
Registered No. *1508*
St..... Ward.....

2. FULL NAME

Jacob Farber
(a) Residence. No. *4157 Easton* St., *11* 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 *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 *Rebecca Farber*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 7 1946*

7. AGE YEARS *83* MONTHS *8* DAYS *3* If LESS than 1 day,hrs. ormin.

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

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

10. NAME OF FATHER *Wolfgang Farber*

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

12. MAIDEN NAME OF MOTHER *Carla Altemus*

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

14. INFORMANT *George Farber* (Address) *4157 Easton*

15. FILED 19..... REGISTERAR *Max C. Staley*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 10 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 1926* to *Feb 10 1930* that I last saw him alive on *Feb 10 1930*, and that death occurred, on the date stated above, at *10* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Crohn's Disease Chronic
13F (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *1290* (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF... WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *H. A. Thompson* M. D. 19 (Address) *Geveling Beer*

*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 *7 13 1930*

20. UNDERTAKER *Adolf S. Schmidt* ADDRESS

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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