

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

Do not use this space.

6782

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis, Mo. (No. 2506 N. 13th) St. _____ Ward _____

2. FULL NAME

Adam Alter
 (a) Residence. No. 2506 N. 13th St. 26 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 4, 1856

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|--------|-------|--------|------|--|
| | 73 | 11 | 9 | |

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

9. BIRTHPLACE (CITY OR TOWN) Illinois
 (STATE OR COUNTRY)

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Veronica Mauch

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

14. INFORMANT Mrs. Marie Grunwald
 (Address) 2506 N. 13th St.

15. FILED FEB 15 1931 Max C. Hanker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/13 1930

17. I HEREBY CERTIFY, That I attended deceased from 1/1/30 to 2/13/30, 1930, and that I last saw him alive on 2/13, 1930, and that death occurred, on the date stated above, at 1:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
chronic myocarditis
arterio-sclerosis

93C
 97 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 90 B (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 90 B
 IF NOT AT PLACE OF DEATH.....

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

WHAT TEST CONFIRMED DIAGNOSIS? Echocent M. D.
 (Signed) 2/14, 1930 (Address) 1807 518

*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 Bellefontaine Cemetery DATE OF BURIAL 2/15/1930

20. UNDERTAKER Bergesch Mfg. Co. 3661 Washington St. 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.

