

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

Do not use this space.

7060

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **City**) **Hopfer** St. _____ Ward _____

File No. _____
 Registered No. **1927**
 Ward _____

2. FULL NAME

(a) Residence No. **16880** **John Dallas** _____ Ward _____
 (Usual place of abode) **822 Idaho** _____ (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **63** 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 **single** (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec 5 1876**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	53	7	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Carpenter**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER **Julius Dallas**

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

12. MAIDEN NAME OF MOTHER **Anna Schwartz**

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

14. INFORMANT **John Dallas**
 (Address) **City of St. Louis**

15. FILED **1930** **17**
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 27 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 27 1930** to **Jan 27 1930** that I last saw him alive on **Jan 27 1930**, and that death occurred, on the date stated above, at **6:30 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

125 B
Abscess of Liver (Right Lobe)
~~causative organism~~ **not determined** (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH **8202 Idaho**

DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **Feb 15, 1930**

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) **Ben Margulies** M. D.

1130 (Address) **City Hospital**

*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. Olive Cem.** DATE OF BURIAL **2/24 1930**

20. UNDERTAKER **St. Hoffmeister White** ADDRESS **714 Broadway**

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.

atlas.