

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

Do not use this space.

10325

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 003  
City St. Louis mo. (No. 4125 W. Bell St.)

File No.....  
Registered No. 2300  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 4319 Tyler Ave St. 16 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) April 14/1867

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
62 10 18

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) on Farm  
(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Germany

10. NAME OF FATHER Andrew Siegel

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

12. MAIDEN NAME OF MOTHER J. Vollmer

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

**14.**

INFORMANT Mrs. Carrie Newberry  
(Address) 4319 Tyler Ave

**15.**

FILED 19 Mar C. Stanley REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 4<sup>th</sup> 1930

17. HEREBY CERTIFY, That I attended deceased from Feb - 24, 1930, to Mar - 4, 1930 that I last saw him alive on Mar - 4, 1930, and that death occurred, on the date stated above, at 11:50 A. m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Post Operative Venereal Meningo  
Brachio Pneumonia  
127 B  
107 B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Brachio Pneumonia (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, DID AN OPERATION PRECEDE DEATH? Yes DATE OF Feb - 27 - 30

WAS THERE AN AUTOPSY? No

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) Charles H. Smith M. D.

Mar 5, 1930 (Address) 305 Metropolitan 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. Pauls Church Yard DATE OF BURIAL March 7 1930

**20. UNDERTAKER**

J. H. Gebken L. O. Co. ADDRESS 2628 Grannis

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.

*Ad*

