

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

Do not use this space.

11107

**1. PLACE OF DEATH**

County St. Louis Registration District No. 01  
Township St. Louis Primary Registration District No. 003  
City Missouri (No. City Infirmary)

File No. \_\_\_\_\_  
Registered No. 3143  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence No. City Infirmary 19 Ward.

Length of residence in city or town where death occurred 62 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>abt. 85</u>	<u>?</u>	<u>?</u>	<u>?</u>	

**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) Odd jobs  
(c) Name of employer \_\_\_\_\_

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

10. NAME OF FATHER W. J. Harder

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

12. MAIDEN NAME OF MOTHER Emilia Harder

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

14. INFORMANT Mrs. M. Effinger  
(Address) City Infirmary

15. FILED 19 19 19 19 19 19 19 19 19 19  
W. C. Harder REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-23 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-1 1930, to 3-27 1930 that I last saw him alive on 3-22 1930, and that death occurred, on the date stated above, at 1:30 A. m.

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

Chronic Myocarditis  
930

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) ? yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_ (duration) ? yrs. mos. ds.

8 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) Belkhebel M. D.

3-24-1930 (Address) 5600 avenue

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

St. Louis U. 3126 1930

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

Walter Richter 3500 Rutger St.

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.

