

MAY 28 1930

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

Do not use this space.

13930

1. PLACE OF DEATH

County St. Louis
Township Carondelet
City Koch

Registration District No. 1123Primary Registration District No. 8248B(No. Koch Hosp.)

File No. _____

Registered No. 109

St. _____ Ward _____

2. FULL NAME Vickers, John

(a) Residence No. 819 N 14th St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 8 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

Single6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 16, 1902

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

27922

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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Idaho
(STATE OR COUNTRY)10. NAME OF FATHER John Vickers11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ido
(STATE OR COUNTRY)12. MAIDEN NAME OF MOTHER Adele Terrall13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ido
(STATE OR COUNTRY)14. INFORMANT Koch Hospital Records
(Address) Koch Ho.15. Am. 9 FILED 1930 L.C. Obrock M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 8 1930

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1927, 19____, to April 8, 1930, 19____, that I last saw him alive on April 8, 1930, 19____, and that death occurred, on the date stated above, at 4:20 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis23AAbout (duration) 3 yrs. 6 mos. ds.CONTRIBUTORY (SECONDARY) Unknown

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH UnknownDID AN OPERATION PRECEDE DEATH? NO DATE OF _____WAS THERE AN AUTOPSY? NOWHAT TEST CONFIRMED DIAGNOSIS? X-Ray Sputum
(Signed) R.H. Ehrlich M. D.4/8/30 (Address) Koch 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

DATE OF BURIAL

Calvary Apr 11 1930

20. UNDERTAKER

ADDRESS

Ziegenhain Bros 2623 Cluopa

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.

