

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

Do not use this space.

14127

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **Barnes Hospital**)

File No.....
Registered No. **3457**
St. Ward.....

2. FULL NAME **ALBERT SOLLEIS JR.**

(a) Residence. No. **1315 FRANKLIN AVE.** St. Ward.....
(Usual place of abode) **COUNTY** (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) married
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
Agnes Solleis

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
About 33	—	—	—	—

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

9. BIRTHPLACE (CITY OR TOWN)..... **St. Louis**
(STATE OR COUNTRY)

10. NAME OF FATHER **Albert Solleis**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **Agnes Solleis**
(Address) **1315 Franklin Ave St. Louis**

15. FILED **APR -7- 1930** **May C. Stanley** REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4-6 1930**

17. I HEREBY CERTIFY, That I attended deceased from **3-9**, 19**30**, to **4-6**, 19**30**.
that I last saw **h.e.m.** alive on **4-6**, 19**30** and that death occurred, on the date stated above, at **7:57 A.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Emphysema
Sclerosis of Pulmonary Arteries
(duration) **2** yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Cordive Failure**
(duration) yrs. mos. **14** ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS? **Kroy**

(Signed) **W. H. Tanner** M. D.

41 W. 1930 (Address) **Barnes 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 **Calvary** DATE OF BURIAL **4-8 1930**

20. UNDERTAKER **Arthur J. Connolly** ADDRESS **2089 Wash 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.

