

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

Do not use this space.

14275

File No. _____
Registered No. 3614
St. _____ Ward _____

1. PLACE OF DEATH

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

2. FULL NAME

(a) Residence. No. 2534 open St. 19 Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 3 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 (using the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 14 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 11 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Lather
(b) General nature of industry, business, or establishment in which employed (or employer). as above
(c) Name of employer Henj Hutz

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

PARENTS
10. NAME OF FATHER Gus Ogulsky
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Steuersky
12. MAIDEN NAME OF MOTHER Mam Modiker
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) St. Louis

14. INFORMANT (Address) City No. 1003

15. FILED May 11 1930 Max C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 9 1930

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1930 to April 9, 1930 that I last saw him alive on April 9, 1930 and that death occurred, on the date stated above, at 11:27 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

CONTRIBUTORY (SECONDARY)

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical, X-ray, Sputum
(Signed) Carl J. Hutz M. D.
49 1930 (Address) City No. 1003

*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 Xenia Ills DATE OF BURIAL April 12 1930

20. UNDERTAKER W. H. ... ADDRESS 4234

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.

WRITE PLAINLY, WITH UNPADDED INK—THIS IS A PERMANENT RECORD

Agley