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

Do not use this space.

14465

File No. 3809

Registered No.

791
1003

1. PLACE OF DEATH

County

Township

City St Louis (No. City Hospital #1 St. Ward)

Registration District No.

Primary Registration District No.

2. FULL NAME Michael Heller

(a) Residence. No. 3720 Koscinsko St., Ward.
(Usual place of abode)

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) December 23-1903

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	26	3	21	

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

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

PARENTS

10. NAME OF FATHER Rudolph Heller

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

12. MAIDEN NAME OF MOTHER Mary Flattinger

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

14. INFORMANT Ruth Heller
(Address) 3720 Koscinsko St.

15. FILED 1930 Mary C. Harper REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 17 1930

17. No Physician in Attendance

I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....
that I last saw h..... alive on ....., 19..... and that death occurred, on the date stated above, at 1.20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock, Injuries (Fractured skull) due to falling from window at 3616 N. S. Broadway
186H
..... (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(SECONDARY) Accident
..... (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) John Hurley, M.D.

4/15, 19 30 (Address) Deputy Coroner

*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
Mem St Marys	April 17 1930
20. UNDERTAKER	**ADDRESS**
Tolmendes Funeral Co	1718 Lo 9th

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 INDELIBLE INK—THIS IS A PERMANENT RECORD