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

Do not use this space.

14501

1. PLACE OF DEATH

County ..... Registration District No. 791 ..... File No. .....

Township ..... Primary Registration District No. 1003 ..... Registered No. 3847

City St. Louis (No. ISOLATION HOSPITAL St. 24th Ward)

2. FULL NAME Frank Jaster

(a) Residence. No. 4298 St. Louis St., 11 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. 7 mos. 18 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	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 27, 1890

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	39	7	18	

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) .....
(c) Name of employer .....

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

PARENTS

10. NAME OF FATHER John Jaster

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

12. MAIDEN NAME OF MOTHER Frances Zangotky

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

14. INFORMANT Loraine Kroner
(Address) ISOLATION HOSPITAL

15. FILED ..... 7 ..... 19 ..... Wm. C. Hardy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-15 1930

17.
I HEREBY CERTIFY, That I attended deceased from 4-8, 1930, to 4-15, 1930 that I last saw h. alive on 4-15, 1930 and that death occurred, on the date stated above, at 4:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Delirium Tremens
1-2
(duration) ....yrs. ....mos. 16 ds.

CONTRIBUTORY (SECONDARY) Cirrhosis of Liver
Alcoholism (duration) ....yrs. ....mos. 8 ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) R. L. Kilbourne M. D.
4-15, 1930 (Address) ISOLATION 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	4-17 1930
20. UNDERTAKER	ADDRESS
Arthur J. Donnelly	2029 Wash.