

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

Do not use this space.

14699

1. PLACE OF DEATH

County.....

Registration District No. **791**
1003

Township.....

Primary Registration District No.

City *St. Louis Mo.* (No.) *Sanitarium*

File No.
Registered No. **4102**
St. Ward)

2. FULL NAME *Vict Men*

(a) Residence No. *813 So Vandeventer St.* *13* Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *15 yrs. +* mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>white</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Single</i>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>about 66</i>				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Unknown*
(b) General nature of industry, business, or establishment in which employed (or employer) *"*
(c) Name of employer *"*

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Austria*

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Dr. Muller, M.D.*
(Address) *5490 Arsenal*

15. FILED *1930* *Wm C. Harbo*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-19 1930*

17. I HEREBY CERTIFY, That I attended deceased from *12-14*, 19*30*, to *4-19*, 19*30* that I last saw h. *alive* on *4-19*, 19*30*, and that death occurred, on the date stated above, at *12:40 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

93C
162
Chr. Myocarditis
(duration) yrs. mos. *6* ds.

CONTRIBUTORY (SECONDARY) *Trichity*
(duration) yrs. mos. *6* ds.

18. WHERE WAS DISEASE CONTRACTED *1015*

IF NOT AT PLACE OF DEATH *no*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical.*
(Signed) *Dr. Muller*, M. D.

4-19 1930 (Address) *5400 Arsenal*

*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

Potters Field *4-24 1930*

20. UNDERTAKER ADDRESS

William Kohler, 5800 Arsenal

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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