

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

Do not use this space.

14878

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St Louis Mo (No.) City Hospital #

File No.
Registered No. 4294
St. Ward)

2. FULL NAME

(a) Residence. No. Unknown St. 23 Ward. 8

(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) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 1

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. abt. 46

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) Unknown
(c) Name of employer Unknown

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

10. NAME OF FATHER Peter Kesting

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT John P. Kesting
(Address) 4836 Bezel Ave

15. FILED FR 313 13 May 1st 1930
19. May C. Harker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 28 1930

17. No Physician in attendance. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19....., and that that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at 842 P m.

195 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & injuries, fractured skull

(duration) yrs. mos. ds.
CONTRIBUTORY Manner & cause could (SECONDARY) not be ascertained. (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

IF AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Dr. Hurler M. D.

4/30 1930 (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 St Matthew DATE OF BURIAL May 1st 1930

20. UNDERTAKER W. Robert Love ADDRESS 1905 Grand

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.

