

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

Do not use this space.

17582

1. PLACE OF DEATH

County..... Registration District No. 701
 Townshp..... Primary Registration District No. 1002
 City St. Louis No. City Hospital #1 St. _____ Ward)

2. FULL NAME

(a) Residence. No. Bloomington Ill 23. Ward. Bloomington Ill
 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 19 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
61 | 1 | 21

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

9. BIRTHPLACE (CITY OR TOWN) La
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm. J. Kussmann

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

12. MAIDEN NAME OF MOTHER Harriet Newman

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

14. INFORMANT Roberta Kussmann
 (Address) 5352 Page St

15. FILED May 11 1930
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 1930

17. No Physician in Attendance
 I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at 12450

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bichloide of Mercury
(self-administered)
1630 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED 1666
 IF NOT A PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) J. W. Kerner M.D.
5/11 1930 (Address) Dep Corcoran

*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 New Orleans La. DATE OF BURIAL May 12 1930

20. UNDERTAKER Philander Craig ADDRESS Washington

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.

10
3
2

