

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*

17822
File No.
Registered No. *4942*
St. Ward)

2. FULL NAME

Emil Subair
(a) Residence. No. *6808 Minnesota* St., *1* 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Agnes Raschdorf*

17. I HEREBY CERTIFY, That I attended deceased from *May 19 1930* to *May 19 1930*
that I last saw him alive on *May 19 1930* and that death occurred, on the date stated above, at *8:30 a. m.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 11 1875*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Peritonitis
127 1/2
129

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 0 8

CONTRIBUTORY (SECONDARY) *Acute Cholecystitis*
(duration) yrs. mos. *5* ds.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Plate Examiner*
(b) General nature of industry, business, or establishment in which employed (or employer) *Hammer Dry Plate Co.*
(c) Name of employer

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. *6808 Minnesota*

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

1 DID AN OPERATION PRECEDE DEATH? *no* DATE OF *5/15/30*

10. NAME OF FATHER *Emil Subair*

WAS THERE AN AUTOPSY? *no*
WHAT TEST CONFIRMED DIAGNOSIS *physical clinical & labatory*
(Signed) *N. H. Kuetters* M. D.

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

12. MAIDEN NAME OF MOTHER *Mrs. Salmaser*

5/20 1930 (Address) *3608 S Grand Bl.*

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

*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.

14. INFORMANT *Gertrude Tralle*
(Address) *3000 Clanton Av.*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *No. Crematory* DATE OF BURIAL *5-22 1930*

15. FILED *May 20 1930* REGISTRAR *W. C. Kaveloff*

20. UNDERTAKER *Witt Bros. L. & U. Co 2929 S. Jefferson* ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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