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

Do not use this space.

18069

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 18069

Township ..... Primary Registration District No. 1003 Registered No. 5226

City St Louis (No. City Hospital St. ..... Ward)

2. FULL NAME Frank Sohnt

(a) Residence. No. 3418 Utah St., 16 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

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

5A. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF Mary Sohn

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 15 1869

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	60.	6.	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Glazier 210M
(b) General nature of industry, business, or establishment in which employed (or employer) Pullman Car Co
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Casper Sohn

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mary Sohn
(Address) 3418 Utah St

15. FILED MAY 28 1930, 19 ..... Mary C J Tarlo REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 27 1930

17. No Physician in attendance
I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19..... and that death occurred, on the date stated above, at 6.30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & Injuries (Fractured Skull)
Struck by Fleet
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) St Louis Mo.
Whether Criminal or Accidental not ascertained
(duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kerner M.D.

5/28, 19 30 (Address) Det-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 SS Peter & Paul — DATE OF BURIAL May 30 1930

20. UNDERTAKER Thos Kutis — ADDRESS 2906 Gravois Av

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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