

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

Do not use this space.

18147

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis, Mo. (No. Sanitarium Ward)

File No.
Registered No. 5305
St. Ward)

2. FULL NAME

(a) Residence. No. 4510 Shenandoah St. #613 Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. + mos. da. How long in U.S., if of foreign birth? yrs. mos. da.
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov. 19-1864</u>		
7. AGE	YEARS <u>65</u>	MONTHS <u>6</u>
	DAYS <u>11</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Lumberman</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>Unknown</u> (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-30 1930

17. I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1930, to May 30, 1930 that I last saw him alive on May 30, 1930, and that death occurred, on the date stated above, at 2:00 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

critical contraction & diverticulum of Oesophagus (duration) yrs. 1 mos. 17 ds.
CONTRIBUTORY acute psychosis (SECONDARY) (duration) yrs. 1 mos. 17 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: no
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? clinical, X-Ray & autopsy
(Signed) Dr. Muller, M. D.
5/30, 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.

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Dr. Muller M. D.
(Address) 5400 Arsenal

15. FILED May 31 1930 REGISTRY

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Valhalla Crematory DATE OF BURIAL May 31 1930

20. UNDERTAKER Wm. Schlicwacker ADDRESS 3013 Meramec

X. 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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