

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

Do not use this space.

20574
~~20672~~

1. PLACE OF DEATH

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

Registration District No. *1123*
Primary Registration District No. *6248 B*
(No. *Koch Hospital*)

File No. _____
Registered No. *204*
St. _____ Ward)

2. FULL NAME

(a) Residence. No. *443 Cayle* St., _____ 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* *Widowed*

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

Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *4-1-1874*

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

56 *2* *14*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Iron Moulder*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Pa. Unknown*

10. NAME OF FATHER *Andrew Carson*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Unknown*

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Unknown*

14. INFORMANT *Koch Hospital*

(Address) *Koch mo*

15. FILED *6/16/30 L. C. O'brouck*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6-14-1930*

17. I HEREBY CERTIFY, That I attended deceased from *3* 19*29*, to *6-14-1930* that I last saw him alive on *6-14-1930*, and that death occurred, on the date stated above, at *5am 6-14-30* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
VDR
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH *unknown*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *Ray of Sputum*

(Signed) *P. L. Ehrlich*, M. D.

6/16/30 (Address) *Koch Hosp*

*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

Calvary Cemetery

DATE OF BURIAL

June 28 1930

20. UNDERTAKER

J. H. Gebken L. & W. Co. 2842 Myra

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

