

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

Do not use this space.

20616
~~20714~~

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City, *St. Louis, Mo* (No. *40*) *St. Lukes Hospital* St. **5353** Ward

2. FULL NAME

Jacob Becker
(a) Residence No. *5946 Dignemille* **5** Ward.
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *unknown*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
about 70 — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer) *Carpenter*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *Russia*

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Mrs. Becker*
(Address) *1212 S. Franklin*

15. FILED *2* 1933 *May 27* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 1* 19 *30*

17. *No Physician attended*
HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., and that

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... *1:50 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock & Injuries (Fractured skull) Struck by auto in St. Louis, Mo. 7/2/29
..... (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Accident*
..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH?..... DATE OF..... *20*

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. W. Tenner, M.D.*
6/2/30 (Address) *Dep. Corona*

*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 DATE OF BURIAL

Chesed Shel Emeth *June 4 1930*

20. UNDERTAKER *H. Rindkopf*
ADDRESS *5216 Delmar*

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.

