

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

Do not use this space.

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1. PLACE OF DEATH

County.....
Township.....
City..... *St Louis Mo* (No.)

Registration District No. **791**
1003
Primary Registration District No. **3018 Keokuk**

File No.....
Registered No. **5431**
St..... Ward.....

2. FULL NAME

(a) Residence. No. **3018 Keokuk** St., **16** Ward. (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 **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb 29. 1840**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
90 3 4

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... **Truck Gardener**
(b) General nature of industry, business, or establishment in which employed (or employer)..... **own Business**
(c) Name of employer..... **Quincy Ill**

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Quincy Ill**

10. NAME OF FATHER **Unknown Halz**

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 **Edith Ruderhoeffer** (Address) **3018 Keokuk St.**

15. FILED **MAY -4 1930** REGISTRAR **Mar C Stanley**

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 2. 1930**

17. I HEREBY CERTIFY, That I attended deceased from **May 11th**, 19**30**, to **June 2**, 19**30** that I last saw h... alive on **June 2**, 19**30**, and that death occurred, on the date stated above, at **1 P.m.**

THE CAUSE OF DEATH WAS AS FOLLOWS:
Hypostatic Pulmonary Congestion
1868
1914
11113 (duration) yrs. mos. **13** ds.

CONTRIBUTORY (SECONDARY) **fracture neck of femur due to fall to floor at residence** (duration) yrs. mos. **3** ds.

18. WHERE WAS DISEASE CONTRACTED **Accident** IF NOT A PLACE OF DEATH **home**

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF **✓** WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS **X Ray** (Signed) **A A Gethardt**, M. D. (Address) **3438 Chippewa**

*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 **Quincy Ill** DATE OF BURIAL **JUNE 4 1930**

20. UNDERTAKER **Wm J Robert** ADDRESS **1905 S Grand Blvd**

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.

