

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

Do not use this space.

20751 ~~2049~~

1. PLACE OF DEATH

County _____
Township _____
City St. Louis (No. City)

Registration District No. 791
Special Registration District No. 1003
Hospital # 1

File No. _____
Registered No. 5545
St. _____ Ward) _____

2. FULL NAME

John Fiock
(a) Residence No. Bachelor Hotel St. 22 Ward.

(Usual place of abode) 1206 Chouteau (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) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 26 1890

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>59</u>	<u>5</u>	<u>10</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mechanic Auto
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Fred Fiock

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

12. MAIDEN NAME OF MOTHER Isabell Schmiede

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

14. INFORMANT Frank Fiock
(Address) 617 1/2 Alabama Ave

15. FILED 11N - 7 1930 REGISTRAR W. C. Stanley

MEDICAL CERTIFICATE OF DEATH

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

17. No Physician in Attendance
I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
121
Chronic Interstitial Nephritis
_____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Cedema of Brain
(SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 1290
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. Fenner, M.D.
117 1/2 30 (Address) St. Charles

*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 W. St. Marcus
DATE OF BURIAL 6-9 1930

20. UNDERTAKER W. C. Schumacher
ADDRESS 3013

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.

