

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

Do not use this space.
21004
~~21002~~
File No. _____
Registered No. **5834**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **701**
Township _____ Primary Registration District No. **203**
City **St. Louis** (No. **6443 Alabama Ave**) St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ 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 Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Etta		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 19, 1863		
7. AGE	YEARS 66	MONTHS 8
	DAYS 25	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Clerk (b) General nature of industry, business, or establishment in which employed (or employer) Records office (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Missouri		
PARENTS	10. NAME OF FATHER Henry Klaus	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany	
	12. MAIDEN NAME OF MOTHER Augusta Schaber-Kostler	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany	
14. INFORMANT Etta Klaus (Address) 6443 Alabama Ave		
15. FILED Jun 16 1930 New U. Starker REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 14 1930**
17. I HEREBY CERTIFY, That I attended deceased from **June 15, 1929** to **June 14, 1930**
that I last saw him alive on **July 14, 1930**, and that death occurred, on the date stated above, at **2:35 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
92A Cerebral apoplexy
82A Aortic regurgitation
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
0 DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____
WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) **A. W. Peters**, M. D.

*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 **St. Trinity Lutheran** DATE OF BURIAL **6/17 1930**
20. UNDERTAKER **Fort-Independence Co. 781 1/2 Belmont** ADDRESS _____

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

25
1
10

