

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

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210976
File No. _____
Registered No. **5948**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis** (No. **City Hospital**)

2. FULL NAME

Andrew Halg
(a) Residence. No. **2115 Biddle** St. **21** 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 **Ellen Halg**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 7, 1866**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
69 0 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Farmer**
(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) **Indiana**

10. NAME OF FATHER **Andrew Halg**

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

12. MAIDEN NAME OF MOTHER **Unknown**

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

14. INFORMANT **Walter Halg**
(Address) **1471 Grand St.**

15. FILED **11 1920** **Max C. Starnes** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) **6-17 1930**

17. I HEREBY CERTIFY, That I attended deceased from **July 11, 1927**, to **June 11, 1930**, that I last saw him alive on **June 17, 1930**, and that death occurred, on the date stated above, at **10:55 P. M.**

59 THE CAUSE OF DEATH* WAS AS FOLLOWS:
108 P. Leukemia mellitus
97 Lobar Pneumonia 2 days
(duration) **5** yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Neuritis (Leukemic?) arteriosclerosis**
(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) **D. N. Feller**, M. D.

6/18 . 1930 (Address) **3505 N. Grand**
*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** DATE OF BURIAL **6-20 1930**

20. UNDERTAKER **Arthur J. Donnelly** ADDRESS **2039 Wash St**

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.

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