

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

Do not use this space.

21287

~~21287~~

1. PLACE OF DEATH

County..... Registration District No. **791**
 Townshp. *St. Louis* Primary Registration District No. **1003**
 City *St. Louis* (No. *4161*) *Glasgow Ave* St. _____ Ward _____

2. FULL NAME

John Broder
 (a) Residence. No. *4161 Glasgow* St., *10* 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 (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mrs. Anna Broder*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept. 13, 1843*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
86 9 10

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. *General Laborer*
 (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) *Germany*

10. NAME OF FATHER *Not known*

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

12. MAIDEN NAME OF MOTHER *Not known*

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

14. INFORMANT (Address) *Mrs. Lucy Glasgow 4161 Glasgow Ave*

15. FILED *May 21 1930* REGISTRAR *Math. Hermann*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 23 1930*

17. I HEREBY CERTIFY, That I attended deceased from *June 10*, 1930 to *June 23*, 1930. that I last saw him alive on *June 22*, 1930, and that death occurred, on the date stated above, at *5:20 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Bronchitis non tubercular
106 A (duration) yrs. mos. *12* ds.

CONTRIBUTORY (SECONDARY) *99A* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____ WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *A. Mellis*, M. D.

Jun 24, 1930 (Address) *3825 N 20"*

*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 *Friedens* DATE OF BURIAL *June 20 1930*

20. UNDERTAKER *Math. Hermann* ADDRESS *2161 E. Farr Ave*

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.

