

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

Do not use this space.

24821

1. PLACE OF DEATH

County.....
Township.....
City St. Louis

Registration District No.
Primary Registration District No.

File No.
Registered No. 6980
St. Ward)

2. FULL NAME

Harry Adler
(a) Residence. No. 2827 Dickson St., 21 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)

Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
<u>about 24</u>			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Cabinet Maker
(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) Austria

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) not known

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) not known

14.

INFORMANT Sam Rudman
(Address) 2827 Dickson St.

15.

FILED 15 1932 Map C Stanley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 13 1930

17. I HEREBY CERTIFY, That I attended deceased from Dr. P. Physician in attendance

....., 19....., to....., 19....., and that that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... 5:15 A..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1911 Isolation
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1911
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

18 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) J. W. Keenan, M.D.
7/15 1930 (Address) Dep. Corv

*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

Chered Shel Emeth

DATE OF BURIAL

7-15-1930

20. UNDERTAKER

H. Rindskopf

ADDRESS

5216 Delmar

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

