

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

Do not use this space.

24838

**1. PLACE OF DEATH**

County

Registration District No.

791  
1003

Township

Primary Registration District No.

City

File No.

Registered No.

6997

**2. FULL NAME**

(a) Residence

(Usual place of Abode)

3966 Olive

St.

19

Ward.

(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): Single

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

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

July 12, 1890

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day; .....hrs. or .....min.

40

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Chef

(b) General nature of industry, business, or establishment in which employed (or employer)

Ins. Teller

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Italy

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Italy

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14. INFORMANT

(Address)

Mrs. Florence Kelly  
1122 No Taylor

15. FILED

19

July 13 1930

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

July 12, 1930

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. .... alive on ..... 1930, and that death occurred, on the date stated above, at ..... 2:30 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

191

Heat Prostration

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. W. Feyer, M.D.

7/15, 1930 (Address)

\*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

DATE OF BURIAL

Calvary Cemetery July 16, 1930

20. UNDERTAKER

ADDRESS

Stroob & Cannon Northdgr

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.

