

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

Do not use this space.

25049

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis Mo. (No. Alexian Bros Hospital) St. _____ Ward _____

File No. _____
 Registered No. 7232

2. FULL NAME Seymour Abraham

(a) Residence. No. 5891 Washington St. 5 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

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Label Abraham

7. DATE OF BIRTH (MONTH, DAY AND YEAR) July 25 1870

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
59 11 24 — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) Clothing Merchant
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Merionville (STATE OR COUNTRY) Pa.

10. NAME OF FATHER Emanuel Abraham

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

12. MAIDEN NAME OF MOTHER Clara Schloss

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

14. INFORMANT Clarence Abraham (Address) 5891 Washington

15. FILED JUL 21 1930 W. C. H. Harkley REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19, 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to July 19, 1930, that I last saw him alive on July 19, 1930, and that death occurred, on the date stated above, at 4:55 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

93C

89 (duration) yrs. mos. ds.

CONTRIBUTORY Terminal Dementia (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 90B

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) H. H. Harkley, M. D.

July 20, 1930 (Address) 325 Frisco Bldg.

*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. Louis Cemetery DATE OF BURIAL July 21 1930

20. UNDERTAKER H. Rindt 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.

