

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

Do not use this space.

25116

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1000

City St. Louis (No. City Hospital)

File No.

Registered No. 7317

St. Ward

2. FULL NAME

(a) Residence. No. 418 Lucas St. 25 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT

(Address)

15. FILED

NOV 22 1930

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 4 1930

I HEREBY CERTIFY, That I attended deceased from July 3 1930 to July 4 1930 that I last saw him alive on July 4 1930 and that death occurred, on the date stated above, at 8:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Artery metastasizing to Cervical Glands Tracheostomy (old)

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Terminal Fatal Hemorrhage (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? Yes DATE OF Unknown

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Carl J. Foster M.D.

7/4 1930 (Address) City Hospital

*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

Washington U.

7-15 1930

20. UNDERTAKER

ADDRESS

Walter Richter

3500 Rutger St

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.

Mohr.

24
8