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

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.

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

Do not use this space.
28494

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 7003 Registered No. 8397

City St Louis (No. ISOLATION HOSPITAL St. 24th Ward)

2. FULL NAME Oliver Gassner

(a) Residence. No. 210 Marion St., 23 Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 29, 1910

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	19	11	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN) St. Louis Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Gottlieb Gassner
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Frank
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

14. INFORMANT C. Sheridan
(Address) ISOLATION HOSPITAL

15. FILED AUG 23 1930, 19 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 21 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 21, 1930 that I last saw him alive on Aug 21, 1930, and that death occurred, on the date stated above, at 3:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Typhoid Fever
1 29
(duration) yrs. mos. 25 ds.

CONTRIBUTORY (SECONDARY) Perforated Typhoid Ulcer with Peritonitis (duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? yes DATE OF 8-21-30
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) B. Kuhbiel, M. D.
8-21, 1930 (Address) ISOLATION 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: S S Peter & Paul Cem
DATE OF BURIAL: 8/[illegible] 1930

20. UNDERTAKER: Weick Bros 2201 Ro Grand
ADDRESS