

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 1003

File No. 28513
Registered No. 8418
St. Ward)

2. FULL NAME

(a) Residence. No. 6132 Crescent Ave. St. 4 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 29, 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day laborer
(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 Miss Anna M. Winkler
(Address) 6132 Crescent Ave

15.

AUG 25 1930 FILED 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 24 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 - 1930, to Aug 24 1930, that I last saw him alive on Aug 24 1930, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

Carcinoma of Stomach
Secondary Anemia
40 B (duration) yrs. mos. ds.
71 B
CONTRIBUTORY Operative Shock
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 8-24-30 -

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Operative
(Signed) Scheelants / Shult M. D.

8-24 1930, (Address) 305 North 1st St, St. Louis, Mo

*State the DISEASE CAUSING DEATH, or if death from VIOLENT CAUSE, state (1) MEANS and NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Friedens Aug 25 1930

20. UNDERTAKER Mat. Hermany and Son 261 E. Fair Ave

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.

