

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

Do not use this space.

31659

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **Southern Hospital**)

File No.

Registered No. **9311**

St. Ward)

2. FULL NAME

(a) Residence. No. **3223 Porter Ave St. 16** 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)

Widowed

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

Annie Weber

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

Aug 4 - 1854

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
76	1	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **Retired Patern maker**
 (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) **Germany**

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Unknown**

14.

INFORMANT **Mrs Myrtle Volker**
 (Address) **3223 Porter Ave**

15.

FILED..... 19.. **May 21 1930**
May C. Stankley
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 **16. DATE OF DEATH (MONTH, DAY AND YEAR)** **Sept 25 1930**

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to Sept 25, 1930, that I last saw him alive on Sept 25, 1930, and that death occurred, on the date stated above, at 2:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma Liver 46 B
Carcinoma Stomach 46 E

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. **At place of death.**

DID AN OPERATION PRECEDE DEATH? **No** DATE OF

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Physian Exam**
 (Signed) **A. J. Plog**, M. D.

9-25-1930 (Address) **3150 W. Myrnford**

*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

Cemetery

DATE OF BURIAL

Sept 27 1930

20. UNDERTAKER

Clement and Co. S. Grand Blvd

ADDRESS **2217**

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.

