

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

Do not use this space.

**34820**

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City..... (No. **St Anthony's Hosp**) St. .... Ward)

File No. **10215**  
 Registered No. **10215**

**2. FULL NAME**

**Leo Bernard Bethel**

(a) Residence. No. **939 Morrison Ave**, **NV** Ward. (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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct 24th 1930**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**3**

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work **108**  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

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

10. NAME OF FATHER **Ben F Bethel**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **West Louisville**  
 (STATE OR COUNTRY) **Kentucky**

12. MAIDEN NAME OF MOTHER **Sally Johnson**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Needmore**  
 (STATE OR COUNTRY) **Kentucky**

14. INFORMANT **Ben F Bethel**  
 (Address) **939 Morrison Ave**

15. FILED **27 1930** **Max E Starch** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 27 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Oct 24 1930** to **Oct 27 1930** that I last saw him alive on **Oct 27 1930**, and that death occurred, on the date stated above, at **9.30** **A.** m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Pneumonia due to Lobar aspiration of amoneta fluid**

CONTRIBUTORY (SECONDARY)

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH **St Anthony Hospital**

DID AN OPERATION PRECEDE DEATH? **—** DATE OF **—**

WAS THERE AN AUTOPSY? **—**

WHAT TEST CONFIRMED DIAGNOSIS **usual signs**  
 (Signed) **Anthony P. Schick** M. D.

**10/27 1930** (Address) **3606 Gravois**

\*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. J. Peter & Paul Cong** DATE OF BURIAL **10-28-1930**

20. UNDERTAKER **Witt Bros L & Co 2928 So Jefferson** ADDRESS

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.

WHILE PRINTING WITH UNFADING INK—THIS IS A PERMANENT RECORD

