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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. 781

Township..... Primary Registration District No. 1003

City St Louis Mo. (No. Lutheran Hosp St. ..... Ward)

File No. 37417

Registered No. 10461

2. FULL NAME Michael Fleischmann

(a) Residence. No. 4195 Sacramento Ave St., 10 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 20 - 1867

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	7	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Germany
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Michael Fleischmann

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY) Germany.

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY) Germany.

14. INFORMANT Katherine Fleischmann
(Address) 4195 Sacramento Ave

15. FILED ..... 19.. Herb C Waller
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 3rd 1930

17. I HEREBY CERTIFY, That I attended deceased from June 19th to Nov 3rd 1930, to ..... 1930 that I last saw h.. alive on Nov 3rd 1930, and that death occurred, on the date stated above, at 5-30 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma Stomach.
46 a
1 2 4 H W (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Obstruction, Sigmoid Colon (duration) ..... yrs. ..... mos. 14 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH? Yes. DATE OF July 19 30

WAS THERE AN AUTOPSY? No. Oct. 27 30

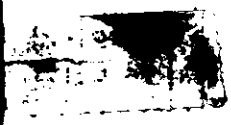
WHAT TEST CONFIRMED DIAGNOSIS? X Ray & operation.

(Signed) W. Jackson Miller, M. D
, 19 (Address) 304 Merchants Exch Bldg

*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 Oak Grove — DATE OF BURIAL Nov. 6 1930

20. UNDERTAKER Ky Leidner Undertaker — ADDRESS 1417 N. Market St.

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.