

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

Do not use this space.

37421

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... **St. Louis** (No. **1112**) **John Doe** St. Ward)

File No.....
Registered No. **10465**
St. Ward)

2. FULL NAME

(a) Residence. No. **1112** **John Doe** St. 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) **Widower**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **July 4, 1854**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 3 29

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Retired Mail Carrier**
(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)

10. NAME OF FATHER **Henry Scharfow**

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

12. MAIDEN NAME OF MOTHER **Widow Schuidde**

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

14. INFORMANT **John Scharfow Jr**
(Address) **1112 John Doe**

15. FILED **Nov 5 1930** **Wm E Stork** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from **June** 19**24** to **July 3** 19**30**, that I last saw him alive on **Dec. 13** 19**29** and that death occurred, on the date stated above, at **2:30** p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of prostate gland

CONTRIBUTOR (SECONDARY) **49** (duration) **1** yrs. **5** mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **yes** - DATE OF **July 19 29**

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS? **Laboratory**

(Signed) **Dr. Ruediger** M. D.

, 19 (Address) **1006 Paul Robeson**

*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 DATE OF BURIAL

New Bethel **Nov. 6 1930**

20. UNDERTAKER ADDRESS

Math. Hermann **2161 E. Fair Ave.**

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.

WRITE PLAINLY, WITH UNBOLDING INK—THIS IS A PERMANENT RECORD

